

**Family Planning and Population
Programs in Colombia
1965 to 1997**

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by

Judith Seltzer
Fernando Gomez

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Edited and Produced by

Population Technical Assistance Project
1611 North Kent Street, Suite 508
Arlington, VA 22209 USA
Phone: 703/247-8630
Fax: 703/247-8640
E-mail: poptech@bhm.com

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LIST OF ABBREVIATIONS

ACEP	<i>Asociación Colombiana para el Estudio de la Población</i>
AIDS	acquired immunodeficiency syndrome
APHA	American Public Health Association
ARS	<i>Administradoras del Regimen Subsidiado</i> (health organizations for individuals who cannot pay for health insurance)
ASCOFAME	The Colombian Association of Medical Schools
AVSC	AVSC International
CA	Cooperating Agency
CBD	community-based distribution/distributor
CCRP	<i>Corporación Centro Regional de Población</i>
CELADE	<i>Centro Latinoamericano de Demografía</i> (Latin American Demographic Center)
CIDA	Canadian International Development Agency
CPJMF	Presidential Council for Youth, Women, and Family/ <i>Consejería Presidencial para la Juventud, la Mujer y la Familia</i>
CRESALC	Regional Committee for Sex Education in Latin America and the Caribbean–Colombia
CSM	contraceptive social marketing
CUIP	University Centers for Population Research/ <i>Centros Universitarios de Investigación en Población</i>
CuT	Copper “T”
CYP	couple year of protection
DANE	National Administrative Department for Statistics
DEP	Division of Population Studies
DHS	Demographic and Health Survey
ENDS	<i>Encuesta Nacional de Demografía y Salud</i>
EPS	<i>Entidades Promotoras de Salud</i> (health insurance organizations similar to Blue Cross and Blue Shield in United States)
FNC	National Federation of Coffee Growers
FPA	Family Planning Association
FUDESCO	Foundation for Development of Health Education in Colombia
FUNOF	<i>Fundación para la Orientación Familiar</i>
GOC	Government of Colombia
GOV	Government of Venezuela
GTZ	Association for Technical Cooperation (Germany)
HIV	human immunodeficiency virus
ICSM	International Contraceptive Social Marketing Project
IDRC	Canada’s assistance agency
IEC	information, education, and communication
ILO	International Labour Organization
INOPAL	Operations Research in Family Planning and Maternal-Child Health for Latin America

IPPF	International Planned Parenthood Federation
ISS	Colombian Social Security Institute
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JICA	Japan International Cooperation Agency
JOICFP	Japanese Organization for International Cooperation in Family Planning
JSI	John Snow, Inc.
LAC	Bureau for Latin America and the Caribbean
MCH	maternal and child health
METROSALUD	Metropolitan Health Institute of Medellín
MOH	Ministry of Health
NCIH	National Council for International Health
NEWVERN	USAID Contraceptives Management Information System
NGO	nongovernmental organization
PAHO	Pan American Health Organization
POPTECH	Population Technical Assistance Project
PRB	Population Reference Bureau
PROFAMILIA	<i>Asociación Pro-Bienestar de la Familia</i>
PRO-PATER	<i>Promocao de Paternidade Responsable</i>
RFP	request for proposal
SENA	<i>Servicio Nacional de Aprendizaje</i> (vocational training supported by a payroll tax)
SOMEFA	Medical Pharmaceutical Society/ <i>Sociedad Médico Farmacéutica</i>
TFR	total fertility rate
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
VSC	voluntary surgical contraception
WHO	World Health Organization
WHR	Western Hemisphere Region

EXECUTIVE SUMMARY

Introduction

The decline in fertility and the role of family planning in Colombia are considered among the success stories in the Latin American and Caribbean region, as well as for the population field as a whole. From the mid-1960s to the mid-1990s, Colombia experienced an impressive reduction in fertility from an average of seven children per woman to three children, plus a substantial increase to more than 70 percent in contraceptive use. The total size of the Colombian population was 37.8 million in 1997. If fertility had not declined, and if high rates of population growth had persisted, Colombia's population would be more than 30 percent larger than it is today.

The reasons for these dramatic changes are many, but the role of family planning and population programs in Colombia in both the private and public sectors is the primary focus of this report. The report describes key factors that help explain the changes and the evolution in the development of family planning. It also documents a number of the lessons learned so that other programs might benefit from the experience of Colombia.

Colombia's success in family planning is based, in large measure, on the *Asociación Pro-Bienestar de la Familia*/Association for the Well-being of the Colombian Family (PROFAMILIA), a private nonprofit association affiliated with the International Planned Parenthood Federation (IPPF). PROFAMILIA became one of the most effective private sector programs, serving a larger proportion of its country's population than does any other private organization in the world. The success in Colombia is all the more surprising, given that the country has never had an official population policy or consistent, strong support from the Government of Colombia (GOC) for family planning. Further, the Catholic Church in Colombia has always opposed artificial methods of birth control, and leftist political forces have objected to population assistance from foreign governments.

Beginning in the mid-1960s, the U.S. Agency for International Development (USAID) and other donors provided substantial support for family planning, both to the GOC and to the private sector. Much of the assistance was directed to the development of PROFAMILIA. In 1996, USAID provided its final grants for family planning, because Colombia was then considered a graduate of USAID assistance. Other donor support is continuing to the public sector and to PROFAMILIA, but at lower levels than in earlier years.

Seeds of Change

High levels of population growth first sparked alarm among health professionals in Colombia who were increasingly aware of the health problems resulting from very high fertility. Colombian women and public health officials were facing growing health burdens associated with illness and death caused by unwanted pregnancy and illegal abortion. Declining mortality, increasing levels of literacy and education, and growing numbers of

Colombians moving to cities were changing the desire for large families. Furthermore, many of the country's professionals were aware that population growth in Colombian communities was out of balance with the available resources needed to support good health, education, and housing.

Enabling Factors

Among the major factors that contributed to the achievements in family planning and population programs was the **commitment made by a number of key Colombian institutions**. First among them was the Colombian Association of Medical Schools (ASCOFAME). The deans of the medical schools of ASCOFAME who were farsighted and concerned medical physicians, set up the Division of Population Studies in the mid-1960s. From this base, the first family planning services were initiated, along with the first demographic research and program evaluation studies. A number of other organizations in Colombia contributed to the development of a strong research ethic, thus providing a solid base of information, a good understanding of the problems, and a careful study of the acceptability and impact of new service delivery programs—all of which helped to support and defend the new programs.

The leaders of ASCOFAME, in concert with a number of private U.S. organizations (e.g., the Ford Foundation, the Rockefeller Foundation, and the Population Council) and numerous U.S. universities, supported extensive training that produced **a cadre of well-trained, committed Colombian professionals**. This multidisciplinary team of sociologists, economists, anthropologists, lawyers, communications experts, and many physicians and nurses understood the serious population problems facing the country. The investment in human resources during the first decade of family planning and population activities has proved to be one of the most important contributions—certainly a second key factor—to the Colombian story.

The availability of **external assistance** from the first days of family planning and population activities is a third key factor. The total level of assistance may have been about US\$125 million over a 30-year period, although there is no complete accounting of the total. The amount of funding was clearly important, but equally important were the timing of the assistance (funds that were readily available when needed for trying new approaches and expanding service delivery) and the flexible mode of assistance through the Cooperating Agencies (CAs) in population. Furthermore, the variety in the funding sources resulted in some specialization, in that certain funding agencies concentrated their assistance on different Colombian organizations (e.g., USAID, the various CAs and IPPF that fund PROFAMILIA, and the United Nations Population Fund (UNFPA) that funds the Ministry of Health (MOH) program).

In 1966, USAID was the first bilateral donor to Colombia. From 1966 to 1996, USAID contributed more than US\$50 million, primarily through the intermediary, private CAs to PROFAMILIA but also to the GOC once the bilateral program ended in 1977. IPPF's support to PROFAMILIA was especially important over the years, because a large

proportion of its annual donation provided core support for personnel and administrative costs.

The CAs were also an important source of technical assistance and funds, primarily to PROFAMILIA and, to a lesser but still significant extent, to the MOH. The CAs' contribution has been substantial, although it is impossible to assess that contribution in quantitative terms. An in-country presence is one aspect of CA assistance that is considered to have been very effective. The individuals representing these organizations were not only technically very qualified, but also culturally attuned.

Another aspect of the CAs' contribution is the broad range of technical areas of assistance provided through their projects. This assistance was tapped to provide the particular expertise needed at any given time in Colombia, be it data collection; research; evaluation; training; information, education, and communication (IEC); service delivery; or commodities. Not only was the range of expertise available through these projects very broad, but also the mode of assistance was extremely flexible. Subprojects were developed and funded quite rapidly. This flexibility in particular characterized the CAs' relationship with PROFAMILIA. Having private institutions—the CAs on the one hand and PROFAMILIA on the other—at the heart of the assistance relationship facilitated the development and innovation of PROFAMILIA and thereby the rapid expansion of the program's service delivery coverage.

The relationship between CAs and PROFAMILIA is viewed by many individuals associated with the program over the years as having been mutually beneficial. For example, the initiation of PROFAMILIA's rural community-based distribution (CBD) program was also the beginning of applied, or operations, research in Colombia. Not only did the family planning and research communities in Colombia benefit, but also a good number of researchers from the international community and from population programs in other countries learned the tools of their trade through operations research at PROFAMILIA.

Colombia was not unique in the wide range of sources of support and the types of assistance that it received. The amount of assistance through nongovernmental organizations (NGO), including the USAID CAs, is considered by some to have been very important. The level of support ranged from relatively small (grants of US\$1,000) to substantial (grants in excess of US\$400,000). The total level of support from NGOs is estimated at about US\$87 million, or about 70 percent of all external assistance. It was the most important channel of assistance to Colombia. The consensus is that these funds were well invested in Colombia's family planning and population programs and were managed carefully and properly.

The development of family planning services in Colombia benefited from the availability of **modern contraceptive technology**. Most contraceptive methods were introduced in Colombia as soon as they were available on the commercial market. Changes over time in the contraceptive method mix used by Colombians show a steady increase in the use of modern methods. Although female sterilization has become the predominant method,

Colombian women and men have consistently taken advantage of the range of modern methods at their disposal. In this regard, Colombia differs from some other nations in the region that are seen as “one method” countries, such as Brazil and the Dominican Republic, because the Colombian mix of modern methods is more balanced.

The **attitudes and behavior of Colombian women** are important factors in the story of rapid fertility decline and dramatic increase in the use of modern contraception in Colombia. In the 1960s, there was a sizable gap between women’s actual fertility and their stated ideal. Further, women had very favorable attitudes toward family planning. These survey data suggested that women were poised to limit their family size and to take advantage of modern contraception, just as efforts to develop family planning programs were getting under way.

Population Policy

Despite the GOC’s interest in family planning in the late 1960s, no official, long-lasting population policy was ever promulgated. In Colombia’s pluralistic political climate, it is not surprising that successive administrations had varying levels of interest in this issue and offered varying levels of support for the MOH’s program of service delivery.

Official policy statements by Colombian leaders were an important indication of a consensus (sometimes openly expressed, but always underlying) that the population problem was serious and required action. The consensus was sufficient for a tacit understanding to emerge between the public and private sectors, and that understanding, in effect, defined the leaders’ respective roles in family planning. The political support that did exist was not sufficient to develop a strong public program, but was sufficient to enable the private sector to step into the void and play an increasingly important role in the delivery of family planning services. Furthermore, the private sector also benefited from the absence of legislation that might have prohibited the development of family planning. The attitude of Colombians has traditionally been that what is not expressly prohibited is permitted. In general, the state does not play a predominant role in the lives of Colombians, as has been the case in other Latin American countries.

Population policy development did occur in Colombia, but it was subtle and pragmatic and it provided the necessary environment for a private family planning organization to expand and thrive. Further, efforts to codify population policy in Colombia might have impeded programs, because the parties opposed to fertility reduction and artificial birth control methods would have surely had their day in court. According to Colombia’s experience, the development of a consensus among leadership groups in the public and private sectors is necessary, whether or not this consensus becomes codified as an official policy.

The various GOC laws passed in the 1990’s suggest that, for all intents and purposes, Colombia now has a population policy that addresses fertility and the family planning needs of its citizens. An additional policy effort that addresses the role of population distribution in sustainable development may be forthcoming. Colombia now appears to

have an effective population policy on fertility and family planning, and it is a characteristically pragmatic one.

Key Actors

The GOC's role in family planning began in 1969 when the MOH established a Maternal and Child Health Division. This Division inherited the service delivery programs of ASCOFAME and used its network of health centers and hospitals to provide contraceptive services that were part of its maternal and child health program. Although the MOH never played a predominant role in service delivery, for various reasons, it did provide services on average to about 25 percent of all users. Furthermore, it refrained from using its regulatory capacity to control or impede the offering of family planning services by the private sector.

Teaching hospitals, which generally belong to the public health system in Colombia, played an important role in developing family planning programs in the late 1960s and early 1970s. They served as the initial sites for service programs, trained personnel to manage the introduction of contraception, and carried out research. In 1972, most family planning and research activities were curtailed because of student unrest. For more than two decades, medical students received no training in contraception and thus were unprepared to offer services during their one year of service in rural areas. Fortunately, in the 1990s, some schools of medicine began to reintroduce teaching about contraception, and the medical curriculum is being revised to reflect interest in family planning.

The private sector in Colombia played the most significant role in developing family planning. From the mid-1960s to the present, PROFAMILIA has dominated the field of family planning. PROFAMILIA helped create a consciousness of family planning in the minds of Colombians. Furthermore, it has served both as a national and a regional center for training human resources and as a center for demonstrating new approaches and activities. In addition to PROFAMILIA, private physicians, who serve about 10 percent of the Colombian population in the general health and contraception area, were generally very supportive of family planning. Scientific medical associations and professional unions supported and defended programs, when necessary. The commercial sector, represented by the pharmaceutical laboratories and pharmacies, locally manufactured key contraceptive products such as the pill and also became the most important source of temporary methods including pills, injectables, vaginal tablets, and condoms.

The communications media played a positive role in the development of family planning and sex education programs and in the fertility decline in Colombia. Radio was an especially effective channel of such communication, as were newspapers. Given the country's democratic political system, the various independent channels of communication served to inform the public on population issues and offered favorable support to family planning.

PROFAMILIA

Colombia's PROFAMILIA is considered a success as an effective, private family planning program. Since the late 1970s, it has been an important source of family planning nationally. Although its share of the market for contraception has declined somewhat in recent years to about 29 percent of all users, it remains the predominant source of sterilization for both females and males and of implants. What sets PROFAMILIA apart from other Family Planning Associations (FPAs) around the world?

Effective Management

PROFAMILIA is a model for managing a nonprofit organization. Since its beginning, the organization's mission and the role of its leaders have been the primary guiding forces. Its mission has consistently been to

Promote and defend the right of access to family planning in Colombia and to provide information and services to all Colombians, especially those with the least economic resources.

The primary element in PROFAMILIA's effective management is its **leadership**. The role of PROFAMILIA's leadership is probably the most important and was certainly the single most cited characteristic of the organization by outside observers. Chief characteristics of PROFAMILIA's leadership are a programmatic approach to program development, a good business sense, and an entrepreneurial spirit.

A second important element in the effective management of PROFAMILIA is the **strategies** it has used over the years **to translate its mission into performance**. For PROFAMILIA, this was primarily a matter of providing good quality services. Delivering quality family planning services created satisfied customers who, in turn, helped create further demand among their friends and neighbors. This basic tenet of the program appears to have been effective. PROFAMILIA also sought to integrate its clients with its mission by testing different approaches to getting services to women wherever they lived. Innovative approaches to service delivery were combined with marketing strategies such as radio announcements and hanging a *bandera verde* (green flag) outside service delivery locations and distribution points so that clients would know where to obtain contraceptive information and services. Two other characteristics of PROFAMILIA's strategies are that (a) innovation was welcomed and supported, and (b) new approaches were tested using research to assess initial client interest and subsequently to evaluate effectiveness.

A third element in the management of PROFAMILIA has been **managing performance by defining performance and then measuring it**. Although it took several years to develop and streamline its monitoring system, by the late 1970s PROFAMILIA had established an effective record-keeping system that provided the needed information on program performance.

The fourth and final element of effective management has been the **people and relationships** associated with PROFAMILIA. The organization has had a good reputation over the years for treating its staff well, paying competitive salaries, and providing motivation beyond paychecks and promotions. The people involved in the organization's work also had good access to information about the program's performance. A regular two-way flow of information between practitioners and top management helped to keep PROFAMILIA in a learning mode. Furthermore, PROFAMILIA has been diligent about publishing articles on its programs and research so that other organizations might benefit from its experiences.

Characteristics of the Service Delivery Program

The evolution of PROFAMILIA's service delivery program was dramatic and rapid. By the end of its first 10 years in business, there were strong signs that PROFAMILIA was an unusual private, nonprofit association. As indicated in Table ES1, the number of clinics grew from only one in 1965 to 42 by 1975. Clinic visits reached well over 300,000, and the cycles of pills sold annually exceeded 2 million by 1975. Although overall prevalence of contraceptive use in Colombia had reached almost 38 percent by 1976, PROFAMILIA's share of the market was nearing one-third (according to a 1978 survey). Furthermore, the organization's income had gone from zero to US\$1.8 million.

Table ES1

**Key Characteristics of PROFAMILIA and Family Planning
in Colombia for Selected Years, 1965-1997**

Characteristics	1965	1975	1985	1995*	1997 (6 months)
No. of clinics	1	42	42	(1994) 48 ^a	35
Service Statistics ^b					
No. of clinic visits	83	341,000	306,000	405,000	328,000
No. of sterilizations	-	9,000	47,000	75,000	52,000
No. of pill cycles sold	-	2,174,000	4,864,000	5,408,000	506,000
No. of condoms sold	-	3,384,000	3,412,000	5,954,000	7,279,000
National prevalence of modern method use	(1969) 18%	(1978) 37.7%	(1986) 52.5%	(1995) 59.3%	n.a.
Percent of modern method users who received services from PROFAMILIA	n.a.	32.5%	38.7%	28.8%	n.a.

Sources: ASCOFAME, 1969; CCRP, et. al., 1979 and 1986; and PROFAMILIA, et al., 1995.

PROFAMILIA, Tables 11, 19, 39, and 42, February 1997 and Table 1,2,6,14, 15, August 1997.

^aThis includes 8 male clinics.

^b Numbers are rounded to the nearest 1,000.

*The last survey was conducted in 1995

These dramatic trends generally continued through 1995 when the number of clinics peaked at 48, the number of clinic visits for family planning surpassed 400,000, the number of sterilizations reached 75,000, and the sales of pills and condoms each exceeded 5 million (cycles or pieces). By 1995, the overall level of contraceptive prevalence had reached 72.2 percent (59.3 percent modern methods), and PROFAMILIA's market share, though still sizable, had declined to 29 percent. PROFAMILIA's income was close to US\$23 million by 1996.

During the 1990s, PROFAMILIA experienced a transition both in terms of its client population and the nature of its services. It was increasingly serving a more middle-class population and offering a diversified range of reproductive health services and of even more general health services. This transition was brought about by the need to become self-sustaining in anticipation of a substantial reduction in external assistance principally because of the end of USAID support. The transition was also spurred by the Colombian health reform, which presented PROFAMILIA with new opportunities for delivering health services, including family planning.

Range of Service Delivery Strategies

During its 32-year history, several characteristics of PROFAMILIA's service delivery program have demonstrated why the organization was so successful. PROFAMILIA began as a clinic-based organization to provide family planning services, but over time it tested various strategies for improved service delivery. The clinic approach quickly evolved to provide access to the large rural population of Colombia. In 1970, working with the Federation of Coffee Growers, PROFAMILIA established the first pilot CBD program in a rural area of Latin America, and the program was one of the first of its kind in the world. Deemed successful, this CBD program was gradually expanded to other coffee-growing areas and then to other rural areas of Colombia. Building on the experience of the rural program, PROFAMILIA launched an urban CBD program in 1973. Only 11 years later, these two programs were merged because their respective territories had begun to overlap.

PROFAMILIA started another nonclinical approach to service delivery through its contraceptive social marketing (CSM) program. Through this program, contraceptives were supplied at subsidized prices to pharmacies, supermarkets, and other commercial outlets. PROFAMILIA approached social marketing from a commercial perspective in working with the pharmaceutical industry in Colombia. Schering, the local pharmaceutical manufacturer, agreed to sell its products wholesale to PROFAMILIA—which could then slightly increase the price and keep a profit—while Schering gained a broader market through PROFAMILIA's clinics and CBD network. Taken together, the CBD and CSM programs reached a wide spectrum of clinics throughout the country.

By the mid-1980s, yet another evolution occurred in the service delivery strategies caused, in part, by the increasing level of contraceptive knowledge and prevalence in the country. The traditional promoter's role in the CBD program was no longer needed. Given the high level of contraceptive knowledge and use, the CBD and CSM programs were transformed into a new “community marketing” approach that relied on a sales force to market pills and condoms.

PROFAMILIA tested other approaches to service delivery including mobile services and clinic services for males and adolescents. These approaches have been retained, but PROFAMILIA has learned that although having separate services for men can be useful, it is not essential as long as special attention is given to male needs.

The evolution in PROFAMILIA's service delivery strategies has run the gamut from a clinic-based program to one that added both community-based and commercial components, plus mobile services. Given that family planning is generally very accessible and the commercial sector is the predominant source of temporary methods, PROFAMILIA is once again emphasizing its clinic-based service.

Contraceptive Method Mix and the Providers' Role

The availability of an increasingly larger mix of contraceptive methods was very important in the development of PROFAMILIA's family planning services. The freedom to choose a method was an important principle that is still very much a part of PROFAMILIA today, because the vast majority of clients obtain their preferred method. With the objective of increasing access to methods, PROFAMILIA was also innovative in changing the roles of services providers (e.g., CBD promoters distributed pills and nurses inserted intrauterine devices, or IUDs). Although these practices are commonplace in many countries today, they were truly innovative in the early 1970s in Colombia.

Contraceptive Commodities

Contraceptive logistics and commodities are an essential component of any effective family planning program. Contraceptives must be obtainable and readily accessible to users at reasonable prices. To ensure good distribution and a reliable supply of contraceptive commodities, PROFAMILIA became involved in marketing, distributing, and selling contraceptives. However, Colombia's experience suggests that the role of the private family planning institution in marketing pills and condoms diminishes as its program matures and as the overall market for these commodities grows. Many functions have been replaced by specialized commercial firms that enjoy a greater capacity in this area and that make PROFAMILIA's role redundant.

Cost Recovery and Sustainability

PROFAMILIA is heralded as a model because of its successful experiences in the areas of cost recovery, cost-effectiveness, and sustainability. Its multifaceted approach to sustainability started with charging fees for services. It moved to developing a good system for tracking the "real" costs of services by method, clinic, and program or delivery strategy. Next it expanded into a broader range of reproductive health services that were provided for a profit and served to cross-subsidize family planning. Then it emphasized efficiency and cost reduction. Finally, in the new era of health reform under Law 100, PROFAMILIA has initiated numerous contracts for family planning and health services with social security and health insurance companies. As a final act in its long support of PROFAMILIA, USAID, through the IPPF's Western Hemisphere Region (WHR), established an endowment fund that moves the organization a step closer to sustainability and gives a welcome cushion for special program needs.

For many years, PROFAMILIA has been the indisputable leader in supplying clinical methods, especially sterilization. Until recently, it has had sufficient strength in the market to ensure the provision of modern contraception such as pills, vaginal methods, and condoms at prices affordable to those least able to pay. PROFAMILIA also established comprehensive programs to educate and inform the community. Thanks to these programs that reached all regions of the country, were developed in a professional way, and

respected local customs, both widespread knowledge and use of contraceptive methods were achieved. Today, the knowledge of methods and of where to obtain them is almost universal in Colombia. As an institution, PROFAMILIA has consistently assessed the usefulness of existing approaches, has been able to modify if not abandon approaches that were no longer productive, and has tested new strategies, always seeking greater effectiveness and efficiency.

The Future

Health reform under Law 100 bodes well for the delivery of general health services to the entire Colombian population. It is transforming both the delivery of family planning and reproductive health services and, most especially, the role of PROFAMILIA. Many opportunities have been created through this reform, and the authors of this report are optimistic about the future of family planning and of PROFAMILIA. Despite this positive view, we recognize that there are continuing needs in the health sector that will require a careful assessment of existing and future human resources. Efforts to institutionalize training in family planning and reproductive health need to be strengthened. Fortunately, promising approaches have been tried in a number of departments.

Continuing Needs

Although the level of contraceptive use in Colombia is high, unmet needs still exist for family planning and reproductive health services. Such needs exist among many groups of women: those who are unmarried but sexually active; those who may be using an ineffective method, yet have a strong desire to postpone or avoid pregnancy; those who may be using a method incorrectly and need better information or different methods; and those who experienced contraceptive failure from a less-effective traditional or folk method. The most striking and troubling unmet need among Colombian women is evident in the high number of abortions. Despite reduced levels of fertility and the wide use of contraception, the incidence of abortion remains unacceptably high and is a critical public health problem in Colombia.

USAID's Future Relationship

After 30 years of assistance in population to Colombia, USAID along with other donors should continue to follow the progress in family planning, the changing role of PROFAMILIA in this era of health reform, and the evolution of overall health reform. A follow-up demographic and health survey should be supported by USAID, other donors, and the appropriate Colombian institutions to track basic demographic and health trends including the use of health and family planning services. USAID should also revisit the family planning and related programs in Colombia in another four or five years to assess how the services have changed under a much transformed health sector. Given the major

commitment that USAID made over the years to PROFAMILIA, special emphasis should be given during any review to assessing changes in the organization's mission, self-sufficiency, types and quality of services, profiles of clients, and changes in contraceptive use.

A reasonable legacy of USAID's past relationship with PROFAMILIA would be USAID's willingness to use its influence in a variety of ways to ensure (a) that PROFAMILIA remains a vital part of the international community of family planning and health providers and (b) that its staff remains technologically up-to-date. The participation of PROFAMILIA in a number of specific areas is suggested along with several recommended actions that would facilitate this participation. Given its past investment in PROFAMILIA and family planning in Colombia, USAID should ensure that the lessons from Colombia's experience and from PROFAMILIA's unique role continue to serve as a model for programs in other countries.

1. INTRODUCTION

1.1 Purpose of the Report

The decline in fertility and the successful role of family planning in Colombia are considered success stories in the Latin American and Caribbean region. Beginning in the mid-1960s, the U.S. Agency for International Development (USAID) and other donors provided substantial support for family planning, both through the government and the private sector. Much of the assistance was directed to developing the *Asociación Pro-Bienestar de la Familia*/Association for the Well-being of the Colombian Family (PROFAMILIA), a private sector organization devoted to providing family planning services in Colombia. PROFAMILIA became one of the most effective private sector programs by serving a larger proportion of its country's population than any other private organization in the world. In 1996, USAID provided its final grants for family planning because Colombia was considered a graduate of USAID assistance. Other donor support is continuing to the public sector and to PROFAMILIA, but at lower levels than in earlier years.

The purpose of this report is to tell the story of Colombia's success in family planning. How was it possible that PROFAMILIA developed into a major provider of family planning in Colombia and that by 1995 over 70 percent of women in union were using some form of family planning? These statistics are all the more surprising, given that Colombia is a country where the Catholic Church opposes artificial birth control, where the government has not been a consistent and strong supporter of family planning, and where leftist political forces objected to population assistance from foreign governments.

Recounting the Colombian experience is important if we are to document why and how these successes were possible. But perhaps more important is to document the lessons learned so that other programs might benefit. Further, the role of the donor community, especially that of USAID, is a critical element in this case history. Appropriate credit is due to the many donor organizations and Cooperating Agencies (CAs) that have contributed to Colombia's population program over the years.

Many observers maintain that the relationship between Colombia and PROFAMILIA is unique and that perhaps few of the lessons learned through their experiences are transferable. The authors of this report believe that PROFAMILIA is unique, but much can be gleaned from telling its story. In fact, the story is not yet over, and some of the greatest challenges lie ahead because of a major transformation that is under way in the Colombian health sector.

1.2 The Colombian Setting

When the eleventh population census was conducted in 1938, more than 120 years after Colombia gained its independence from Spain, Colombia retained demographic characteristics of its colonial past. The total population of 8.8 million was small relative to its geographic size, which is roughly equivalent to the combined area of California and Texas. Nearly 70 percent of the population was rural, and 48 percent of the population was illiterate.

Colombia's demographic characteristics were those of a traditional, agricultural society. Population growth was moderate (less than 2 percent), which was the product of high birth and death rates, a low life expectancy, and virtually no migration in or out of the country. After World War II, the demographic trends began to change. The average mortality rate began to diminish, and there were major gains in life expectancy, giving way to a demographic transition that evolved rapidly. The decline in mortality was due mainly to the reduction in infectious diseases brought about by improvements in public health, hygiene, and sanitation and by the introduction of vaccines and new medicines (e.g., penicillin). By the 1990s, Colombia had achieved an advanced epidemiological transition in which the principal causes of morbidity and mortality were trauma, accidents, violence, and endogenous causes.

Table 1 presents the basic demographic parameters for 1938–1995, the period in which major socioeconomic and demographic changes took place.

Table 1**Estimated Demographic Parameters in Colombia, Selected Periods, 1938–1995**

	1938–1951	1951–1964	1970–1975	1980–1985	1990–1995
Crude Birth Rate	46.5	47.2	32.6	29.0	26.0
Crude Death Rate	22.4	17.4	8.6	6.4	5.8
Rate of Population Growth ^a	~2	3.3	2.5	2.2	1.9
Total Fertility Rate ^b	7+	7.0	4.7	3.4	2.9
Life Expectancy					
Male	40.0	45.5	59.9	64.6	67.1
Female	43.8	50.7	63.5	69.9	72.5
Urbanization (% in urban areas by census year)	30 (1938)	39 52 (1951)(1964)	52 (1973)	67 (1985)	71 (1993)

Sources: Lopez Toro, 1968, and CELADE, 1997.

^a The rates shown are for the following periods: 3.3% for 1951–1964, 2.5% for 1973–1985, and 2.2% for 1985–1993. These are the growth rates most commonly used. The rate of 1.9% for 1964–1973 is considered misleading because the census data are suspect. Adjusted growth rates are 3.1% for 1951–1964, 2.7% for 1964–1973, 2.2% for 1973–1984, and 1.9% for 1985–1993 from the National Statistics Department of DANE and CCRP.

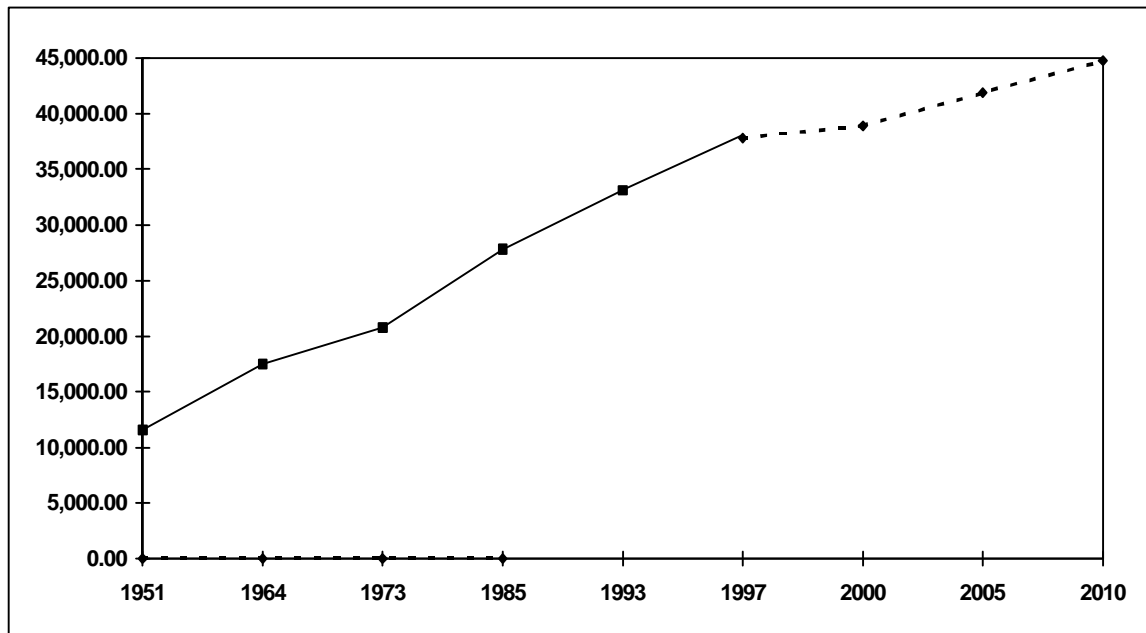
^b The TFRs given in Table 1 are averages for the time periods used in the table. The numbers given for TFRs in Table 8 are for the specific years in which national fertility surveys were carried out. Although the numbers in the two tables differ slightly, the trends they portray are consistent.

From the 1940s to 1960, Colombia's total fertility rate (TFR) was high, averaging around seven children per woman (Elkins, 1973). During the 1951–1964 period and before the initiation of institutionalized family planning programs, the crude birth rate was more than 47 births per 1,000 population, similar to a level of natural fertility. As a result of the decline in mortality and the continuing high fertility, Colombia experienced a dramatic increase in its rate of population growth, reaching 3.3 percent for 1951–1964, an unprecedented level. The high rates of population growth contributed to a very young age structure. In 1964 almost 47 percent of the population was under age 15, thus placing a heavy burden on the government to provide services such as education and health. From 1965 on, Colombia experienced a rapid fertility transition with the TFR declining to 4.7 by 1970–1975 and to 2.9 for 1990–1995. This transition has been the subject of many studies and was widely recognized by the scientific community (Elkins, 1973; Potter et al., 1976; Ochoa, 1982). The important role of the increased use of contraception in the fertility transition is discussed in Section 6.1. The 1993 census indicated that the total population

of Colombia had reached 33.1 million and that growth had slowed to about 2 percent. (See Graph 1)

Graph 1

**Trends in Total Population in Colombia,
1951 to 1993 with Projected Population to 2010**



Source: Several National Census, 1951-1993

Part of the demographic transformation that occurred in Colombia was due to the strong internal migration process and to the impressive flow of residents from rural to urban areas. In 1951, 61 percent of Colombians still lived in rural areas, but results of the 1964 population census showed that a major shift had occurred. The majority of the population (52 percent) now lived in urban areas. This urbanization trend has continued so that by 1993, the year of the most recent population census, 71 percent of Colombians lived in urban areas. The period of rapid urbanization from 1950 to 1964 coincides with a time of generalized violence in rural areas and with the beginning of industrialization that is based largely on import substitution. These two phenomena impelled and accelerated the migratory flow from the countryside, producing rates of annual growth of more than 5 percent in Colombian cities.

Colombia is sometimes referred to as a “country of cities” in that every department, or “state,” has one or more sizable cities. The development of four or five important cities, in addition to the capital, Bogotá, resulted from the country’s geography with its three mountain chains running north and south, effectively isolating the different regions. The growth of numerous Colombian cities contrasts with the urbanization process in several

other countries in the region, which resulted in the primal city phenomenon (i.e., very high growth in one major city such as Lima, Peru). Compared with other countries, such as Brazil and Mexico that are characterized by a number of important cities, Colombia's territory is smaller and thus perhaps more manageable than that of Brazil, which has more than seven times the land area, or Mexico, which has about 1.7 times the area. Thus, the growth of numerous Colombian cities and the manageable size of the country may have been facilitating factors in the creation of an effective service delivery system for family planning.

In addition to these demographic trends, Colombia experienced other socioeconomic and cultural changes that favored and accelerated the transition from high fertility. Impressive positive changes occurred in literacy and in the levels of education. In 1951, 43 percent of the population aged seven and older was illiterate.¹ From 1964 to 1993, illiteracy declined from 30 percent to less than 13 percent. Colombia thus experienced a 70 percent reduction in illiteracy between 1951 and 1993. Illiteracy is distributed almost equally between males and females.

Changes in levels of education have been equally impressive. As shown in Table 2, the percentage of women of reproductive age who have secondary or more schooling increased from 23 percent to nearly 60 percent between 1969 and 1995. The differentials in education between men and women have essentially disappeared, and women now constitute half of the population that attends universities.

Table 2

**Trends in Education for Women in Union of Reproductive Age
in Colombia, Selected Years, 1969–1995**

EDUCATION	1969^a	1976	1978	1986	1990	1995
None	15.7	16.2	13.3	5.7	4.2	3.8
Primary	60.9	54.2	52.9	48.8	41.2	36.5
Secondary ^b	22.1	26.6	30.5	40.6	45.3	49.2
College	1.2	3.0	3.3	4.8	9.4	10.5

Sources: ASCOFAME, 1969; CCRP et al., 1976, 1979, 1986; and PROFAMILIA et al., 1991 and 1995.

^a The urban and rural samples were combined.

^b The 1976 and 1978 estimates are recalculated to separate secondary and college education.

Colombia's progress in literacy and education relative to other countries in the region is interesting. Before 1960, Colombia had actually been among the least literate countries. Then in 1957, the new democratic government voted to give higher priority to public spending for education and health (10 and 5 percent, respectively, of the government's budget). Those increased resources contributed to rapid improvements in education. For

¹ Beginning with the 1964 population census, literacy was measured for the population aged five and older.

much of the second half of the century, Colombia shared an intermediate position in literacy, along with Brazil, Ecuador, Mexico, Panama, Peru, and Venezuela. Argentina, Chile, Costa Rica, and Uruguay were more advanced than Colombia in terms of literacy, while the countries of Central America (with the exception of Costa Rica) had made the least progress. By the early 1990s, four countries (Argentina, Chile, Costa Rica, and Uruguay) had achieved levels of literacy of 93 percent or higher, while Colombia, Panama, Paraguay, and Venezuela made up the second tier of countries with literacy rates from 86 to 90 percent.

Colombia's political system was transformed from a military dictatorship to a democratic form of government in 1957. Colombia was one of two countries in South America (Venezuela was the other) that escaped reverting to a military government in the late 1960s and 1970s. The military dictatorships in Argentina, Bolivia, Brazil, Chile, Ecuador, Paraguay, Peru, and Uruguay opposed family planning at a critical juncture in the development of these programs. In contrast, the political stability of Colombia's democracy, particularly during the early years of the family planning program, set the country apart from many others in the region and no doubt contributed positively to various demographic and socioeconomic changes including the development of a strong private sector role in population activities, especially family planning.

2. HISTORICAL OVERVIEW OF FAMILY PLANNING AND POPULATION ISSUES

This section reviews the initial awareness on the part of key Colombian institutions and the early efforts to address the population problem. It reviews the key policy issues that have been part of the history of family planning and population programs, and then presents five key enabling factors in the development of these programs.

2.1 Initial Awareness and Actions

The first voices of alarm about the increase in population growth in Colombia were those of health professionals. They were aware that more births were occurring, more children were surviving, and more mothers were increasingly looking for ways to avoid having more children. They were also aware of the growing health burden on women and on the health system, especially Colombian hospitals, caused by the illness and death associated with unwanted pregnancy and illegal abortion. Although the pre-transition history in Colombia from 1950 to 1964 is not well studied, the seeds of change in women's attitudes and behavior in fertility and family planning were no doubt related to declining mortality, persistent high fertility, and life in cities where children were more a cost than an asset. The positive attitudes of Colombian women were reflected in their rapid adoption of modern contraception beginning in 1965.

The Colombian Association of Medical Schools (ASCOFAME) was one of the first institutional actors in the population field, and much has been written about its key role (Ott, 1977; Echeverry, 1991). ASCOFAME was set up in 1959 to promote the study of medical sciences. The deans of the medical schools constituted the Board of Directors of ASCOFAME. According to Echeverry (1991), ASCOFAME members were aware that population growth in Colombian communities was very much out of balance with the available resources needed for health, education, and housing. Data from both the 1964 Colombian census and the 1964 Fertility Survey in Bogotá² provided solid statistical evidence of the high levels of fertility (i.e., seven children per woman in union despite the reported ideal family size of 3.6 children) and of the high levels of population growth. This information added impetus to the existing concerns about the health and welfare of the population.

Two important meetings held in Colombia in 1964 and 1965 (ASCOFAME's first National Seminar on Population and the Pan-American Assembly on Population) aimed to increase awareness of population issues. As a consequence of these sessions, the Board of ASCOFAME, which was composed of farsighted and concerned medical physicians, set up the Division of Population Studies (DEP) in 1964 to begin family planning services and

² The multicountry study of fertility in seven Latin American capital cities was supported by the *Centro Latinoamericano de Demografía*/Latin American Demographic Center (CELADE).

to promote both demographic research (especially on fertility) and evaluation of the first family planning service programs.

As this incipient interest in population became manifest, there was a realization, particularly on the part of ASCOFAME's newly founded DEP, that Colombia had neither the experience nor the trained personnel to carry out a research program on population. Thus began a concerted effort to create a cadre of Colombian professionals who would carry out a program of studies in population and family planning (Delgado Garcia, 1966; Echeverry, 1991).

Thanks to support from the Ford Foundation, the Population Council, and USAID (beginning in 1966), professionals from various disciplines including medicine, sociology, economics, and education were trained in many fields related to population and family planning including public health, epidemiology, sociology, statistics, demography, service delivery, and communication. The training was carried out in a number of foreign countries. Colombian physicians were first trained in Chile in contraceptive technology. Many individuals studied at universities in the United States such as Chicago, Cornell, and Johns Hopkins.³ The training included shorter, summer sessions as well as masters and doctoral degree programs. According to a USAID official who worked in Colombia, nearly 4,000 Colombians went overseas for training from the mid-1960s through the late 1970s (Bair, 1978). By the end of the 1960s, Colombia acquired a significant number of trained people who were able to manage research and service programs.

Also during this period, two other research organizations were established to carry out the proposed research: the University Centers for Population Research/*Centros Universitarios de Investigación en Población* (CUIP), and the Colombian Association for the Study of Population (ACEP), a multidisciplinary group established to carry out research and to disseminate information on the population problem.

In 1965, the DEP took a fateful step by expanding the scope of its research program. Through the existing health centers in each of its seven associated medical schools, the DEP began to provide family planning services. "Thus were born the first family planning programs in Colombia" (Echeverry, 1991).

Because of the DEP's initial work, a tradition of research on family planning program activities was generated in Colombia. This strong academic tradition helped defend the early efforts in family planning from its critics. The list of these initial studies is long and impressive and includes not only the 1964 fertility survey cited previously, but also the First National Fertility Survey conducted in 1969 (with urban and rural samples and a subsample of men). The results of this research permitted informed decision making and documentation of accomplishments, practices that continue today.

³ The list of institutions that provided technical and financial assistance is extensive and includes the following besides those cited above: the Milbank Memorial Fund, University of Chicago, University of California, University of Michigan, CELADE, Columbia University, Universidad de Chile, and others (Delgado Garcia, 1966).

The DEP initiated an ample program of publications based on careful studies and original articles by DEP personnel and medical school professors. The program also included the translation of the Population Reference Bureau (PRB) *Bulletins* and the publications of the Population Council, especially *Studies in Family Planning*. These publications were distributed to opinion leaders and to people responsible for political decisions.

In sum, ASCOFAME's leadership role was based, in part, on the development of a multidisciplinary team of sociologists, economists, anthropologists, lawyers, communications experts, and many physicians who understood the major population problems facing Colombia. Its role was also augmented by the importance it gave to research, thus providing a solid base of information, a good understanding of the problems, and a careful study of the acceptability and impact of new service delivery programs—all of which could be used to support and defend the new programs.

Independent of the DEP's efforts to establish the first programs of family planning services in medical schools and the other Ministry of Health (MOH) related institutions, individual physicians also began to provide family planning services. In 1965, Dr. Fernando Tamayo started to provide intrauterine devices (IUDs) to poor women in his private office in Bogotá. Using his personal contacts and overseas trips, he was able to acquire the IUDs necessary for his private practice and sell them to his colleagues. He wanted to set up a small rotating fund to ensure the supply of IUDs, and he was also concerned about training other gynecologists to provide IUDs. From a modest start in the private practice of a well-known doctor in Bogotá arose the *Asociación Pro-Bienestar de la Familia Colombiana*/the Association for the Well-being of the Colombian Family, better known worldwide as PROFAMILIA. (See Sections 2.2.4 and 3.)

2.2 Key Policy Issues

The following sections of the report serve several purposes. First, Section 2.2.1 summarizes a key policy issue—the role of population policy development in Colombia—and offers some conclusions about lessons that other countries might draw from this experience. Second, Sections 2.2.2 and 2.2.5 present briefly the nature of the early opposition to family planning and the role of the communications media. Third, Sections 2.2.3 and 2.2.4 introduce discussions of the roles of the public and private sectors in family planning, which are then presented in greater detail in subsequent sections of the report.

2.2.1 Population Policy Development

Development of a national population policy is generally considered one of the essential elements leading to implementation of effective family planning and population programs. Colombia represents an interesting case, given the initial public statements and actions in the 1960s when more and more countries were acknowledging concern over unprecedented levels of population growth. As early as 1965, Colombian presidential candidate Dr. Carlos Lleras Restrepo spoke of the need to adopt a demographic policy and highlighted the fact that “economic development and social change will be frustrated or substantially slowed if the population continues to grow at current levels.” Later as president, Dr. Lleras was 1 of 12 heads of state (and the only one from the Western Hemisphere) who signed the Declaration of the United Nations on Population Growth and Human Dignity at an international conference in Caracas in 1966 (Escobar Cerda, 1968). In his government, Lleras established a policy of tolerance toward family planning programs that was maintained by later administrations.

In a thoughtful review of the evolution of fertility and family planning policies in Latin America, Colombia is described as “the first country in Latin America to articulate (in 1969) a national population policy based on recognition of the adverse effects of rapid growth. It took steps to integrate population concerns in its social and economic planning” (Merrick, 1990). In 1969, the MOH established a division of maternal and child health with responsibilities that included providing family planning services.

After these efforts to develop a national population policy, subsequent Colombian governments took varying positions corresponding to their political agenda and the political climate, including such factors as the position of the Catholic Church. During the Pastrana regime (1970–1974), various strategies were developed for reducing fertility and influencing the spatial distribution of the population. The National Population Council was formed of cabinet-level ministers, but specific actions to implement the strategies were not carried out. By the 1984 International Conference on Population held in Mexico City, Colombian President Betancur stated that Colombia did not have an explicit population policy “aimed at achieving population targets,” but rather had “a consistent policy of ... improving the living conditions of the population through a comprehensive socioeconomic development strategy” (Merrick, 1990).

¿Tenemos una Política de Población? (“Do we have a population policy?”) is a chapter title in a book on the history of family planning in Colombia (Echeverry, 1991). The author’s view is that Colombia never had a legal, official statute on population and family planning. Not having had such a statute is deemed fortunate because family planning never became the exclusive domain of the government, thereby allowing the private sector to play a major and even predominant role in the delivery of family planning services. Reports from the various national demographic surveys, as well as from PROFAMILIA, conclude that official and explicit population and family planning policies do not exist in Colombia. This was true even though the National Planning Department (*Departamento Nacional de Planificación*) has included population variables in its development plans and programs

for years, and even though the MOH has enabled access to family planning services in its hospitals and health posts. Further, in 1984, the MOH established norms for providing family planning services and specified the state's responsibility for providing contraceptive services including sterilization (*Corporación Centro Regional de Población CCRP et al.*, 1982; CCRP et al., 1987; PROFAMILIA and Macro International Inc., 1991, 1995; PROFAMILIA, 1996).

Recent policy developments show that population concerns and family planning are an integral part of the political scene in Colombia. Article 42 of the 1991 Colombian Constitution states that "couples are entitled to freely and responsibly decide the number and spacing of children they wish to have" (*Asamblea Nacional Constituyente*, 1992). Never before had the Colombian government referred to this subject by means of a decree or a law. In 1993, the Ministry of the Environment was created (Law 99), and among its functions is that "it must, together with the Ministry of Health, draw up a National Population Policy and promote and coordinate programs to control population growth and evaluate national demographic statistics." This effort has not been successful so far because of the weakness of the Ministry of the Environment, its primary interest in the environment component, and its lack of interest and knowledge of population issues. Through the 1993 reform of the social security system (Law 100), family planning for men and women of reproductive age is one of several important reproductive health services that will be guaranteed as part of the basic health care plan. In 1994, the GOC adopted the National Environmental Policy whose main objective is to "gradually advance toward sustainable human development..." Among the activities being considered to improve the environment is the development of a sustainable population policy that would address migration trends and human settlements (PROFAMILIA, 1996).

Did or does Colombia have a population policy? Did its existence—or lack of—matter for the development of an effective service delivery program? In the pluralistic political climate that has characterized Colombia since the 1960s, it is not surprising that successive administrations had varying levels of interest in this issue and that the policy was never implemented or translated into an effective public program of service delivery. This was true despite the GOC's intention in 1969 to provide family planning services within the context of maternal and child health services. The political support that existed was insufficient to develop a strong public program, but it was sufficient to enable the private sector to step into the void and play an increasingly important role in the delivery of family planning services. Furthermore, the private sector also benefited from the absence of legislation that might have prohibited the development of family planning. The attitude of Colombians has traditionally been that what is not expressly prohibited is permitted. In general, the state does not play a predominant role in the lives of Colombians as has been the case in other Latin American countries.

Various GOC laws passed in the 1990s suggest that, for all intents and purposes, Colombia now has a population policy that addresses fertility and the family planning needs of its citizens. An additional policy effort that addresses the role of population distribution in sustainable development may be forthcoming.

What are the lessons from Colombia's experience for other countries and donors who consider that policy development is a necessary step for implementing effective service delivery programs? Official policy statements by Colombian leaders were an important indication of a consensus (sometimes openly expressed) that the population problem was serious and required action. The consensus was sufficient for a tacit understanding to emerge between the public and private sectors that, in effect, defined their respective roles in family planning. Population policy development did occur in Colombia, but it was subtle and pragmatic and it provided the necessary environment for a private family planning organization to expand and thrive. Efforts to codify population policy in Colombia might have impeded programs, because the parties opposed to fertility reduction and to artificial birth control methods would have surely had their day in court. The first lesson is that the development of a consensus among leadership groups in the public and private sectors is necessary, whether or not this consensus becomes codified as an official policy.

A second lesson is that there must be a solid understanding on the part of service delivery institutions (public or private) that a job needs to get done (i.e., that services need to be provided) and that an equally strong commitment to do that job is necessary. After 25 years of providing family planning services, Colombia now appears to have an effective population policy on fertility and family planning. This policy is characteristically pragmatic in that it emphasizes the rights of clients to receive family planning and other reproductive health services and the responsibility of providers to deliver those services.

2.2.2 Sources of Opposition to Family Planning

The traditional opponents of family planning programs in Colombia have been the Catholic Church, its affiliated groups, and the leftist movement. Although these groups were never able to terminate the programs, they did make the job more difficult.

The Catholic Church

From the beginning of its family planning programs to train personnel and provide community services, the DEP looked for the cooperation of important members of the clergy. The presence of those priests in family planning activities was justified by the need to exercise an ethical and moral vigilance over both types of programs, as well as over the content of the information given to the general population. Furthermore, the clergymen could explain the Church's position on family planning to those who attended the sessions. This effective collaboration developed with little interference or misunderstanding until Pope Paul VI issued the *Humane Vitae* encyclical in 1968. Under the encyclical's mandate, which instructed priests not to collaborate with family planning programs and, in fact, to oppose them, a productive relationship between family planning and the clergy was impossible.

From that time on, the Colombian clergy accepted the papal instructions and tried to influence family planning programs. The clergy used the Church's pulpits to warn its followers against the use of artificial birth control methods. However, one

method—periodic abstinence—was sanctioned by the Church and could be used to limit the number of pregnancies. In general, Colombian Catholics accepted the message that it was possible to avoid pregnancies. However, they continued to visit family planning clinics in increasing numbers to obtain more effective methods of birth control that had been rejected by the Church.

How was this divergence possible between the Church's position on birth control and Catholics' behavior? We believe that what happened in Colombia was due to a combination of unique circumstances. First, Colombian women were highly motivated to control their fertility, even though contraception was generally opposed by husbands, families, and the Church. Women's behavior may have reflected the consequences of the rapid process of modernization along with the associated changes of declining mortality, increasing child survival, and rapidly increasing urbanization.

The second important circumstance was the persistence of a democratic regime throughout this entire period. The GOC had sufficient public support to endorse, or at least give tacit approval to, family planning programs without having to negotiate with the Catholic Church as happened in other countries of the region. In contrast to the Church's ineffectiveness in opposing family planning, its opposition to any attempt to legalize abortion in Colombia has been very effective.

The Leftist Movement

The late 1960s and early 1970s were a period of discontent and rebellion among students in the West, and Colombia did not escape this phenomenon. University students in Colombia, particularly those from public institutions, became the focal point of protests against the established system and, in particular, against anything related to the United States. This opposition significantly influenced the DEP's programs. The deans of the schools of medicine, who constituted ASCOFAME's Board of Directors and who were appointed with the student body's support, began to demand the suspension of family planning and population research programs. Starting in the early 1970s, ASCOFAME transferred its service programs to the MOH's new Maternal and Child Health (MCH) Division. The group in charge of the research program also left ASCOFAME and created the *Corporación Centro Regional de Población* (CCRP). The medical schools virtually suspended student training on contraceptive methods and family planning, a situation that has persisted with little change to the present. (See Section 4.1 for discussion.)

2.2.3 The Government's Role in Family Planning

The provision of health and family planning services has traditionally been shared by both the public and private sectors. The GOC never served as the predominant provider in family planning. Until 1993, coverage of general health services was not universal. Approximately 70 percent of the population had access to health care: 40 percent through MOH facilities, 20 percent through the social security program, and the remaining 10 percent from private medicine. Thus, 30 percent of Colombians had no health coverage, a situation that impelled the GOC to approve Law 100 to reform the social security and health care systems. (See Section 7.1 for more discussion.)

The GOC's role in family planning dates back to 1969, when the MOH established the MCH Division and gave it the responsibility for providing family planning services. The Division provided such services through its network of health centers and hospitals, although the MOH was never the major provider of family planning services. (See Section 6.1 for more detail.)

Given a health market segmented between the public and private sectors, the GOC's only means of controlling the market of health services was the MOH's regulation capacity. This capacity was used neither to support family planning programs nor to oppose them. The official policy, never put in writing, basically authorized the provision of services related to limiting fertility in the interest of improved maternal and child health, but there was no plan to limit the size of the country's population. On this basis, the GOC's service programs through its health facilities were defended. At the same time, the GOC did not use its capacity as a regulator to impede the offering of family planning services by private entities.

Further, the GOC never blocked the importation of contraceptive commodities, which are essential to implement family planning programs, nor did it levy high taxes on those products. In the case of the one method (the pill) that is produced locally, the Colombian pharmaceutical laboratories have always been able to count on the necessary raw materials to manufacture oral contraceptives.

2.2.4 The Role of the Private Sector in Family Planning

The private sector entities involved in the delivery of family planning services in Colombia can be divided into three categories: the commercial sector comprised of pharmaceutical laboratories and pharmacies, private physicians, and PROFAMILIA. As mentioned in Section 2.2.1, the lack of official legislation prohibiting or controlling the delivery of family planning or of particular contraceptive methods allowed family planning groups in the private sector to develop and flourish. The role of each of these groups is presented briefly.

Commercial Sector

This sector is represented by the pharmaceutical laboratories and pharmacies. It is possibly the largest market component because most contraceptives such as pills, injectables, vaginal tablets, and condoms are distributed through pharmacies. Oral contraceptives can be acquired in any drugstore without prescription. As with many other prescription drugs, legislation in Colombia requires a doctor's prescription; in reality, this situation is rarely enforced. (This situation is not uncommon in other Latin American countries.)

Pharmaceutical laboratories have complemented the work of drugstores by promoting products, educating physicians, and financing the dissemination of information at professional meetings. As of 1995, Colombian drugstores were serving 33 percent of the overall contraceptive market, but they sold 90 percent of pills, 89 percent of injectables, 95 percent of vaginal methods, and 90 percent of condoms (PROFAMILIA and Macro International Inc., 1995).

Private Physicians

The majority of private physicians in Colombia have long been in favor of family planning programs. Scientific medical associations and professional unions supported the programs and defended them, when necessary. Private physicians have also been providers of these services. As of 1995, private physicians and hospitals provided family planning services to 10 percent of users, a percentage equal to the general health coverage provided by private medicine (PROFAMILIA and Macro International Inc., 1995).

The Medical Pharmaceutical Society/*Sociedad Médico Farmacéutica* (SOMEFA) was established in 1974 to supply private physicians with needed contraceptive commodities. Since its creation, SOMEFA has been dedicated to selling IUDs, condoms, booklets, thermometers (for practicing the rhythm method), and implants of the subdermal contraceptive NORPLANT® through private physicians' offices. In addition, it has distributed educational materials for patients and has carried out related training. SOMEFA had an active participation in training Colombian physicians to use NORPLANT. The total volume of SOMEFA's sales is small compared to those of other programs, but this organization has played an essential role in helping private physicians and hospitals to participate in the contraceptive market.

PROFAMILIA

Established by a group of volunteers in 1965, PROFAMILIA is a private, nonprofit organization in Colombia, affiliated with the International Planned Parenthood Federation (IPPF). Under the direction of Dr. Fernando Tamayo, a well-known doctor who specializes in obstetrics and gynecology, PROFAMILIA was set up to provide family planning services so that families would have an opportunity to regulate the number and spacing of their children. The health needs of many of these women were paramount, given the excessive levels of abortion and the existing use of traditional, less-effective

family planning methods. The founders' motivation was based not only on an observed need among women, but also on a strong desire for equity (i.e., to give the same access and quality of services to these women that wealthier women already had through their private physicians).

From the mid-1960s to the present, PROFAMILIA has dominated the field of family planning in Colombia. PROFAMILIA not only contributed to the development of family planning in Colombia, but also helped to create a consciousness of family planning in the minds of Colombians. It has served both as a national and a regional center for training human resources and as a center for demonstrating new activities. Section 3 of the report discusses at some length why PROFAMILIA became a major service provider of family planning in Colombia and why it is a useful model to study as a private, innovative and highly self-sustainable organization.

2.2.5 The Role of the Communications Media

The consensus among key informants for this report is that the communications media have played a positive role in the development of family planning and sex education programs and in the fertility decline in Colombia. Whenever family planning or PROFAMILIA, in particular, was subject to attack, the media have understood the importance of this issue to Colombia and have supported the programs. (See Section 4.4 for a specific example of the media's role in defending family planning.) On numerous occasions PROFAMILIA staff members have worked with the media in presenting information on sexual and reproductive health. Over the years, a very positive relationship has developed between the media and family planning programs, so that today almost no one in Colombia is opposed to the concept of family planning or to particular methods. In the area of sex and family life education programs, the media have frequently produced programs on such topics, as well as on contraception and adolescent pregnancy. Radio has been an especially effective channel of such communication, as have newspapers. Television, which is controlled by the GOC, has been less active in covering these topics. In Colombia's democratic political system, the various independent channels of communication served to inform the public about population issues and to favorably support family planning.

2.3 Key Enabling Factors in the Development of Family Planning

The achievements of the population program in Colombia are due to a combination of factors that might best be called "enabling factors." Based in part on the preceding discussion, five such factors stand out as the most salient, although no doubt there are other contributing factors. These factors are (a) the commitment of key Colombian institutions, (b) the training of a cadre of Colombian professionals, (c) the role of external assistance, (d) the technological revolution in contraception, and (e) the attitudes of Colombian women.

2.3.1 Commitment of Key Colombian Institutions

Although the role of key Colombian institutions was described in Section 2.1, the following brief discussion highlights the importance of those institutions to population and family planning in Colombia. First among them in the earliest days was the DEP of ASCOFAME. Along with DEP, ACEP, and the CUIPs gave a firm academic underpinning to subsequent policy and program developments. The existence of a strong multidisciplinary team that was based in these research centers was a critical factor in the organizations' effectiveness. Coupled with these efforts was the commitment from the first private sector organization, PROFAMILIA, to provide family planning services in Colombia. The organization's primary objective was to get services to women—especially poor women—who wanted to avoid undesired pregnancies. The combined commitment of the several academic and research organizations along with a service delivery organization was a potent force in the early days of developing the population program in Colombia.

2.3.2 Training of a Cadre of Colombian Professionals

As discussed in Section 2.1, an important investment was made in human resources in the first decade of the Colombian population program. Nearly 4,000 Colombians were trained in Colombia and overseas as a result of the concerted effort to create a cadre of Colombian professionals who would carry out a program of studies in population and family planning. Many of these individuals have worked for years in the population field, both in Colombia and in other countries. Many leaders in family planning in Colombia today consider that the support given to developing human resources was one of the most important contributions to the entire program and was the one that has had the greatest impact over time.

2.3.3 The Role of External Assistance

A third important factor (discussed more fully in Section 5) in the case of Colombia has been the availability of external assistance from the very first days in the development of family planning services and population activities. Initially, this assistance came from private U.S. foundations (Ford and Rockefeller) that were active in the international population field. Soon U.S. bilateral and other funding became available and quickly became a major source of funds, first for the MOH and then for PROFAMILIA through various intermediary technical assistance organizations or Cooperating Agencies (CAs). Other bilateral donor support was provided by Japan, Canada, and Germany. The IPPF was a very important source of initial support for PROFAMILIA and has continued to be a reliable source of funding over the years.

Although it is very difficult to estimate the total level of external assistance in population, the value is probably in the order of US\$125 million over the past 30 years. It goes without saying that the overall amount of funding was important, but of equal importance was the timing of the assistance, because funds were readily available when they were

needed for trying new approaches and expanding service delivery; the flexible mode of assistance through the CAs was also valuable. Furthermore, the variety of funding sources resulted in some specialization in that certain funding agencies concentrated their assistance on different Colombian organizations (e.g., USAID, the various CAs, and IPPF funded PROFAMILIA while the United Nations Population Fund (UNFPA) funded the MOH program).

2.3.4 Technological Revolution in Contraception

The development of family planning services in Colombia takes as its starting point virtually the first days of the revolution in modern contraceptive technology. The oral contraceptive pill was apparently available in Colombia in the early 1960s. In 1964, the pill ranked a low sixth among the women in Bogotá who had used any method of contraception; only 2.4 percent of those women had used the pill and only 5 percent had knowledge of the pill (Miro, 1966). The IUD was introduced in Colombia in the mid-1960s. According to various sources, the first IUDs were carried into the country by individual Colombian physicians in their luggage on return trips from the United States. By 1969, 8 percent of Colombian women had used the IUD, and some 33 percent knew of the method (Estrada, 1972).

Female sterilization was a very rare procedure in the mid-1960s; only 1 percent of women in Bogotá had been sterilized in 1964, although 36 percent of women were aware of the procedure (Miro, 1966). In 1972, training of Colombian physicians in two ambulatory sterilization procedures (laparoscopy and minilaparotomy) began. By 1976, 4 percent of Colombian women ever-in-union and of reproductive age had been sterilized, and an impressive 72 percent of these women had knowledge of this method. Although male sterilization (vasectomy) was introduced in 1970, interest in this method on the part of potential male users lagged for years. Even in 1986, only 0.4 percent of married women of fertility age reported vasectomy as the means of birth control (CCRP et al., 1987). The no-scalpel technique for vasectomy was introduced in Colombia in 1988.

Other modern contraceptive methods were available in Colombia including injectables; 1 percent of currently married women were using injectables in 1969 (CCRP et al., 1982). DepoProvera was consistently available; it was never withdrawn from the market as a result of the lack of U.S. Food and Drug Administration approval as happened in so many other countries. The most recent addition to contraceptive technology, NORPLANT, was introduced in Colombia in 1983 through Phase II clinical trials conducted by the Population Council and the CCRP study.⁴

⁴ Three MOH hospitals were the sites for pre-introduction trials that “typically involve more women and more service sites than clinical trials. They helped to design appropriate training and informational materials for providers and users, acquaint local medical personnel with the methods, and gather country-specific information for local regulatory approval” (McCauley and Geller, 1992).

Colombia's population program has benefited from the availability of modern contraceptive technology. Most methods were apparently introduced in Colombia as soon as they were available on the commercial market. With NORPLANT, the method was introduced as part of clinical research trials and thus without much delay.

As noted in Table 3, changes over time in the contraceptive method mix show a steady increase in the use of modern methods. Although female sterilization is the predominant method, Colombian women and men have consistently taken advantage of the range of modern methods at their disposal. In this regard, Colombia differs from other countries in the region, such as Brazil and the Dominican Republic, because the mix of modern methods is more balanced.

Table 3

Trends in Prevalence of Contraceptive Use by Method for Women in Union of Reproductive Age in Colombia, Selected Years, 1969–1995

METHOD	1969	1976	1986	1990	1995
Pill	8.5	16.2	16.4	14.1	12.9
IUD	3.5	10.4	11.0	12.4	11.1
Injection	NA	0.5	2.4	2.2	2.5
Implant	NA	NA	NA	NA	0.7
Vaginal	2.3	3.4	2.3	1.7	1.4
Condom	2.3	2.1	1.7	2.9	4.3
Female Sterilization	1.6	4.9	18.3	20.9	25.7
Male Sterilization	NA	0.2	0.4	0.5	0.7
All Modern	18.2	34.1	52.5	54.6	59.3
Rhythm	5.5	7.3	5.7	6.1	5.2
Withdrawal	8.8	5.8	5.7	4.8	5.8
All Traditional	14.3	13.1	11.4	10.9	11.1
Folk	2.9	1.0	0.9	0.5	1.8
All Methods	35.4	51.8	64.8	66.1	72.2

Sources: ASCOFAME, 1969; CCRP et al., 1976, 1979, 1981, and 1986; and PROFAMILIA et al., 1991 and 1995.

NA Either the method or data are not available.

Although the availability of a range of contraceptive methods is deemed an important factor in the increasing use of modern methods, what also sets Colombia apart from other countries is the pragmatic and even conservative approach to offering different methods. New methods were introduced only after they had been tested and approved by other countries, particularly by the United States. (The consistent availability of DepoProvera is an exception to this characterization.) In contrast, programs in Mexico and the Dominican Republic were more open to research on new methods. Furthermore, Colombian guidelines for use of methods were cautious and sensible. For example, sterilization was available to individuals over the age of 25 with three or more children and, preferably, with children of both sexes. With PROFAMILIA, official approval of these guidelines was never sought nor deemed necessary; at the same time since the guidelines were sensible, they never created adverse publicity.

2.3.5 Attitudes of Colombian Women

The attitudes and behavior of Colombian women are important factors in the story of the rapid fertility decline and of the steady and dramatic increase in the use of modern contraception in Colombia. Results from CELADE's program of comparative fertility surveys showed that in 1963–1964 nearly 40 percent of women in Bogotá had ever used contraception.⁵ The most common methods of contraception were rhythm, withdrawal, douche, condom, and jelly (Miro, 1966). In a national fertility survey carried out in 1968–1969, 60 percent of women had favorable attitudes toward family planning, with virtually no differences between women from urban and rural areas. About half the women were aware of family planning methods to avoid pregnancy, although the differences by urban and rural residence were striking: 65 percent of urban women and only 36 percent of rural women had such an awareness. Attitudes about family size revealed that 65 percent of women preferred smaller families. The ideal number of children (the “most convenient number of children”) was 3.4 for urban women and 4.4 for rural women (Estrada, 1972). Clearly, most Colombian women were poised to limit their family size and to take advantage of a program of modern contraception just as the efforts to develop programs of modern family planning services were getting under way.

Trends in the ideal number of children reveal a progression toward smaller families for both urban and rural women (see Table 4 and Chart 1). The largest change occurred between 1969 and 1986 when the ideal number declined by nearly one child for urban women and by more than one child for rural women. By 1995, urban women reported that roughly two and a half children were ideal, and rural women stated about three children were ideal. With these trends, it is not surprising that fertility declined steadily while contraceptive use increased. (See Section 6.1.)

Table 4

Trends in Ideal Number of Children for Colombian Women in Union of Reproductive Age by Residence, Selected Years, 1969–1995

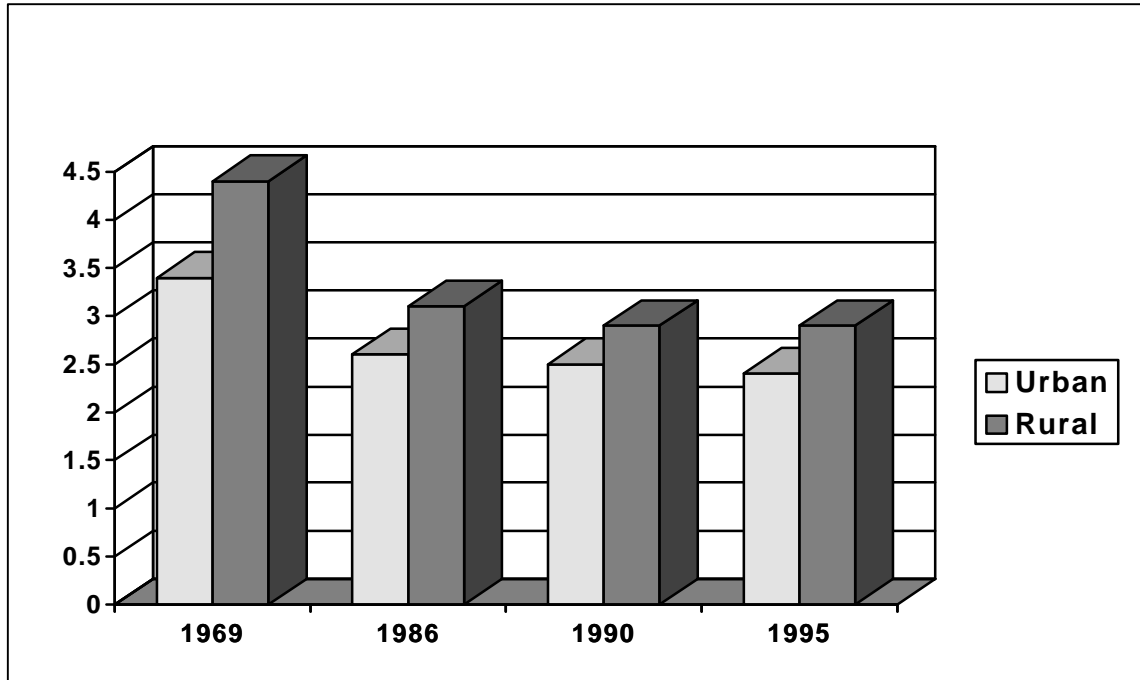
RESIDENCE	1969	1986	1990	1995
Urban	3.4	2.6	2.5	2.4
Rural	4.4	3.1	2.9	2.9

Sources: ASCOFAME, 1969; CCRP et al., 1986; and PROFAMILIA et al., 1991 and 1995.

⁵ This percentage is based on Catholic women who were in legal or common-law marriages. The proportion of Catholics among these women was 98.6 percent in Bogotá so virtually all women in the sample were Catholics.

Chart 1

Trends in the Ideal Number of Children for Colombian Women in Union of Reproductive Age by Residence, Selected Years, 1969-1995



3. PROFAMILIA AS A MAJOR SERVICE PROVIDER IN FAMILY PLANNING

PROFAMILIA has received favorable attention for a number of years and is considered one of the success stories as an effective, private family planning program (Roper, 1987; PROFAMILIA, 1990). Since the late 1970s, PROFAMILIA has been an important source of family planning services in Colombia. In 1978, PROFAMILIA provided contraception to about one-third of all current users and was the primary source of IUDs. By 1986, PROFAMILIA provided contraception to almost 40 percent of all users and was the predominant source of both male and female sterilization and of IUDs. The 1995 survey showed that PROFAMILIA was still an important provider. Although its market share has declined to about 29 percent of all users, it remains the predominant source of sterilization and implants.

The fact that no other private family planning organization in the world has played such a major part in serving a substantial portion of its country's population makes PROFAMILIA unique. What is it about PROFAMILIA that makes it a model of an effective nonprofit organization?

3.1 A Model for Managing a Nonprofit Organization

Four elements in the management of PROFAMILIA help to explain why it is well suited as a case study.⁶ The first element is the primacy of the organization's **mission and the role of the leader**. Since its founding in 1965, PROFAMILIA has had a strong guiding mission: to promote and defend the right of access to family planning in Colombia and to provide information and services to all Colombians, with a special focus on those with the fewest economic resources. As will be seen subsequently, PROFAMILIA tested new approaches and made forays into new territory, but as one longtime observer commented, "There was always something akin to the 'Song of the Siren' bringing PROFAMILIA back to its central mission." (Vernon, 1997).

The role of leadership in PROFAMILIA was probably the single most-repeated characteristic among all people interviewed for this report. PROFAMILIA has had outstanding leadership, beginning with its founder, Fernando Tamayo, who is still the organization's president and a major guiding light, and with other important leaders such as Gonzalo Echeverry (Director of Rural Programs, 1969–1981); Miguel Trías (Director of Urban Programs, 1972–1981, and Executive Director, 1981–1994); and María Isabel Plata (Executive Director, 1994–present). Three characteristics of PROFAMILIA's leadership were cited frequently: (a) a programmatic approach to program development, (b) a good business sense, and (c) an entrepreneurial spirit. These characteristics largely defy quantification; nevertheless, they are recognized as vital. Drucker (1990) states that a

⁶ These four elements are described in Drucker, 1990.

leader must ensure that everyone within the organization sees, hears, and lives the mission. A leader must ensure that the organization is results driven and that the right results are being achieved. A leader must also set the example for the entire organization, must be visible, and must stand for the organization. Evidence for this type of leadership in PROFAMILIA abounds.

The second element in the management of PROFAMILIA has been how it translated its **mission into performance: its effective strategies for marketing, innovation, and fund development**. An organization needs to develop strategies that help move its mission and objectives into actual performance. A first step in this process is to define what the market is, as well as who a customer or client is or should be. From day one, PROFAMILIA's leadership believed that Colombian women wanted contraception and that its guiding strategy was to satisfy those clients. According to Tamayo (1989) and Echeverry (1991), the latent demand for family planning in Colombia was even greater than had been suspected. The steady increase in the level of contraceptive use recorded in the various surveys from 1964 to 1995 confirms that such a demand did and does exist.

Drucker (1990) explains that a nonprofit organization needs a marketing strategy to integrate the customers' needs and the organization's mission. For PROFAMILIA, this strategy was primarily a matter of providing good-quality services. It was strongly felt that women who were satisfied with the services they received would create further demand among their friends and neighbors.⁷ Various commentators noted that Dr. Tamayo used his own private clinic practice, which served upper-class women, as the quality standard for PROFAMILIA's family planning services.

Another way in which PROFAMILIA sought to integrate the customer with its mission was by trying different approaches to bringing services to where women resided. PROFAMILIA had begun as a clinic-based service. In 1971, a rural delivery program was tested through the National Federation of Coffee Growers (FNC) in one department, Risaralda. It was next expanded to other coffee growing areas and then grew into the remaining rural areas of the country. A series of additional innovations in approaches to service delivery followed, all of which helped to bring together clients and PROFAMILIA's mission. (See Section 3.2.1.) For marketing its services over the years, PROFAMILIA has also used different strategies such as using radio announcements of its services and adopting the *bandera verde* (green flag) as its logo so that community-based distributors (CBDs), as well as clinics, would be easily identified by potential clients.

Additional characteristics of effective management of an institution's strategies are as follows: (a) strategies need to improve constantly and to be innovative (PROFAMILIA's history is full of such examples); (b) strategies must begin with research and keep providing more research (as PROFAMILIA matured, it placed more and more emphasis on the role of research in testing new approaches and assessing clients' needs and levels of

⁷ PROFAMILIA has a reputation for women-centered reproductive health services. In fact, given the focus on quality of services and the attention to special groups—be they women, men, or adolescents—staff members are more apt to speak of client-centered services.

satisfaction); and (c) it must develop a donor constituency (PROFAMILIA learned fairly early the importance of having timely information on its program to report to donors about its output and the impact of its activities). Finally, PROFAMILIA was the first Family Planning Association (FPA) in the region to hire a staff for local fund-raising.

The third element in the management of PROFAMILIA has been **managing performance: defining what performance really means and then measuring it**. From the very first day of the first PROFAMILIA clinic, performance was defined as how many people were users, which methods they selected, and how much each client paid for the method. (The authors actually viewed the first record book.) The emphasis on counting clients evolved into a detailed registration system for new acceptors with individual histories of contraceptive behavior. The system was subsequently simplified as the program of service delivery became increasingly more complex. By the late 1970s, PROFAMILIA had already established an effective record-keeping system that provided accurate and timely information on program performance and that is maintained to this day (IPPF, 1979). In addition to monitoring performance, during the 1970s PROFAMILIA developed an extensive program of research that enabled it to evaluate its different program strategies, as well as assess their relative costs. (See Sections 3.2.2 and 3.2.5.)

The fourth element of PROFAMILIA's effective management is referred to as the **people and relationships** associated with the institution. The people include staff, Board members, volunteers, and the community. PROFAMILIA has long had a reputation for treating its staff members well, paying competitive salaries, and providing motivation beyond paychecks and promotions. The ethic of the organization has involved creating a spirit of service and satisfaction in delivering good service. Roper (1987) cites various examples of effective management practices including incentives used to stimulate good staff performance and relations. Furthermore, recruitment, training, and supervision have been used to underscore the importance of good performance.

Under this fourth element, Drucker (1990) also describes the importance of an organization's being information based. The people involved in carrying out the organization's mission—from senior management to clinic staff and field workers—must be informed about how the organization is performing. A regular flow of information from those doing the work to top management and then back down the chain of command “helps to keep an organization in a learning mode.” Here again, PROFAMILIA has shown its effectiveness in using monitoring and evaluation data to keep its Board, program directors, staff, and clinic personnel informed about the program.

PROFAMILIA's Board of Directors is entirely composed of volunteers. These individuals are community leaders in their own right and represent diverse and important areas such as banking, law, business, and investment. Some volunteer members have had an important political influence nationally such as the wife of Virgilio Barco, who was president of Colombia from 1986 to 1990. The Board is not typical of boards that primarily provide financial contributions. Rather, members are genuinely interested in the organization's work, stay informed about its activities, and participate in key institutional decisions. Over

the years, the Board has been very stable, with Dr. Tamayo as its sole president and with little change in membership.

PROFAMILIA's relationship with the community at large is primarily through its services and through periodic studies and assessments of the acceptability of services and client satisfaction. PROFAMILIA's leadership feels it is sufficiently aware of the community's needs that no formal mechanism is needed to involve the community in defining the organization's policies.

The support given to publishing articles on PROFAMILIA's program and research is another aspect of this fourth element in effective management. An impressive body of literature exists on various facets of the program (e.g., the original rural CBD program, the evolution to a commercial marketing program, and the cost-recovery program). Those publications enhance the status of the institution and also allow other organizations to benefit from PROFAMILIA's experiences.

3.2 Evolution of PROFAMILIA's Service Program

The previous section looked at management characteristics of PROFAMILIA to highlight why PROFAMILIA is a successful model of a nonprofit organization and why it is worthy of study. This section reviews a number of important program characteristics and how they evolved over time to keep the organization a strong, vital player in the arena of family planning service delivery in Colombia.

3.2.1 Service Delivery Strategies

PROFAMILIA began as a clinic-based organization that provided family planning services. The first clinic opened in Bogotá in 1965. The rapidity with which additional clinics opened was remarkable: 2 in 1966, 6 in 1967, and 17 in 1968 for a total of 26, which are located mostly in the capital cities of Colombian departments or states. Through these early clinics, PROFAMILIA helped demonstrate that a strong demand existed for family planning services and that it was feasible to provide them (Tamayo, 1978). By 1973 and within eight years of its founding, PROFAMILIA had set up 42 clinics around the country (Echeverry, 1991). By 1994, the organization had 48 clinics in every principal city of Colombia, including eight exclusively dedicated to men (Plata, 1994). By 1997, PROFAMILIA's clinics numbered 36. The eight male clinics are no longer counted as separate units. Five clinics were closed in 1997: three closings resulted from combining resources because the clinics were located near other, larger clinics, and one closing was a consequence of the loss of population and a related decline in service use in a locale affected by violence. The closing of the fifth clinic is a consequence of the changing environment for providing family planning services (discussed in Section 7.1). The primary clients of this last clinic were associated with Social Security and ECOPETEOL, the Colombian oil company. After years of contracting with PROFAMILIA to provide services, these institutions decided to offer services directly.

As shown in Tamayo (1978), part of PROFAMILIA's strategic approach to service delivery involved getting the word out about its services:

Working in an atmosphere of official tolerance, PROFAMILIA made use of the services of an advertising agency to design the first family planning information program in Latin America making massive use of radio, the medium of choice when a significant proportion of the target audience is illiterate. In 1969, spot announcements on the association's family planning services began to go out over the air in a campaign that was eventually carried over three radio networks reaching 75 percent of the country's total population. Every effort was made to ensure that the people who responded to these messages would be given services of unimpeachable medical quality both to forestall attacks on family planning and to gain the support of the medical profession.

Community-Based Distribution

The clinic-based program obviously did not provide access to the large rural population that constituted about 48 percent of the Colombian population in 1970. Following on the heels of the radio campaign, PROFAMILIA solicited the assistance of the FNC in 1970 to set up an experimental family planning program in a few rural areas in the state of Risaralda. This was the first pilot, rural CBD program in Latin America and one of the first of its kind in the world (IPPF, 1980).⁸ The need for services was identified through surveys of *veredas* (villages) that showed families having an average of seven children, although "they wanted and considered ideal" an average of 3.4. The experiment was carried out using the existing structure of the FNC's rural extension agencies. Because of the link to the FNC, the family planning program was considered "part of a wider plan of assistance ... integrated rural development, and ... not an end in itself."⁹ Rural field workers selected from the local area formed the backbone of the program, were responsible for communication and education in their areas, and were full-time employees of PROFAMILIA. Contraceptives were distributed by volunteers in each community. The initial rural CBD program was deemed successful, was gradually expanded to other coffee-growing areas, and then was extended to other rural areas of the country (Echeverry, 1975; Bailey and Correa, 1975).

Building on the experience of the rural program, an urban CBD initiative was launched in 1973. This program, which depended mostly on small shopkeepers (usually women) as distributors of pills, condoms, and (later) vaginal tablets, grew quickly given the following

⁸ The IPPF medical director visited PROFAMILIA's rural program in 1973 and apparently coined the phrase CBD. His subsequent recommendation that IPPF/London set up a department of community programs was apparently followed (Echeverry, 1991) providing an early example of PROFAMILIA's impact on other private family planning endeavors.

⁹ Conversely, Dr. Tamayo believed that "the Colombian experience shows that a direct approach to reducing births rates on a national scale can succeed without waiting for development to take its slow course. Colombia thus provides a model whose implications should at least be explored elsewhere by carrying out trials or tests of the types of programs that have worked in Colombia for the delivery of both information and services" (Tamayo, 1978).

advantages for women: (a) it freed them from having to undergo a medical exam at a clinic, (b) it allowed them anonymity, (c) it saved them time and the cost of clinic fees and transportation, and (d) it provided supply points within easy reach (IPPF, 1979). Furthermore, the urban CBD program gave the urban distributors more time for promotion activities to increase the acceptance of contraception because those distributors spent relatively less time compared to the rural promoters, in collecting information from users.

In a 1979 evaluation, IPPF suggested that PROFAMILIA merge the rural and urban CBD programs since the territory of the two programs was beginning to overlap (IPPF, 1979). These two programs were merged in 1981. By 1993, nearly 4,000 distribution posts were around the country, and for every 30–40 posts, there was a community instructor who had been trained by PROFAMILIA employees and who visited the assigned posts, provided supplies, and augmented the volunteers' knowledge of family planning through discussions, films, and household visits (PRB, 1993).

Contraceptive Social Marketing

Another approach to delivering contraception—social marketing—was initiated in 1973. PROFAMILIA's Contraceptive Social Marketing (CSM) program was part of its non-clinic-based services. Through the CSM program, PROFAMILIA supplied contraceptives at subsidized prices to commercial outlets (pharmacies, supermarkets, etc.). Since the program was designed to produce a profit and thus help subsidize the CBD program, the sale price of the contraceptives was set high enough to keep the program financially self-sustaining, but low enough to put the price within the reach of low-income couples (Tamayo, 1978; Vernon et al., 1988). The CSM program consistently made a profit, reaching its maximum of US\$1 million in 1983.

For years, PROFAMILIA purchased most of its CSM products from local manufacturers by using both donated funds and program revenues. PROFAMILIA sells oral contraceptives in their original packaging and does not repackage as many other CSM programs do.¹⁰ (However, more recently, PROFAMILIA has repackaged condoms.) Several types of locally produced Schering pills were purchased by PROFAMILIA for distribution. Pills, condoms, foaming tablets, spermicides, and (later) IUDs and NORPLANT were supplied by various international donors including IPPF and USAID.

PROFAMILIA approached social marketing from a commercial perspective while working with the pharmaceutical industry in Colombia. For example, it negotiated an arrangement to buy Schering products wholesale and to add a margin of profit, but it would still sell Schering products at a reduced price. The incentive for a local

¹⁰ “The decision not to repackage was partially to avoid the extra costs of changing the packaging when brands of donated contraceptives changed, which they did periodically. Further, PROFAMILIA considered it politically wiser to use existing packaging and keep some distance between the organization's name and a specific contraceptive, given the sometimes politically sensitive climate in Colombia” (Vernon et al, 1988).

manufacturer of pharmaceuticals such as Schering to sell its products wholesale to PROFAMILIA, which would in turn compete with Schering in retail outlets, was the opportunity to broaden its market through PROFAMILIA's clinics and the CBD network (Plata, 1997).

Initially the program was operated by a team of experienced salesmen who were trained by PROFAMILIA in family planning, who canvassed orders and recruited new outlets, and who also monitored the retail price of contraceptive commodities. In 1981, PROFAMILIA switched from employing its own sales staff to contracting with independent wholesalers, who were already wholesalers of other pharmaceutical products, to market their contraceptives so it could thereby reduce the costs associated with salaries, travel, and benefits. The new system still involved local purchase of products, duty on donated contraceptives, transportation to and storage in a central warehouse of all commodities, and transportation to wholesalers' warehouses in five regions of the country.

Taken together, the CSM and CBD programs reached a wide spectrum of clients, with CSM serving higher-income clients and with CBD providing information and commodities to lower-income clients. The CSM program was promoted through mass media and point-of-purchase materials, as the instructors or promoters provided their information through the CBD. While the CSM program consistently produced a profit, the cost per couple year of protection (CYP) for the two programs combined was about US\$1.50, or similar to the cost of social marketing programs elsewhere (Samuel, 1982).

Community Marketing

With increasing levels of contraceptive knowledge and use, PROFAMILIA's experience suggested that a transition in the CBD and CSM strategies was needed to reduce costs without sacrificing contraceptive use. By the mid-1980s, profits from the CSM program had dropped "to almost nonexistent" (Trías, 1992) as a result of various factors including the higher cost of acquiring contraceptives, the MOH's assigned selling price of certain "drugs," the GOC's prohibiting the sale by nonprofit organizations of donated products to wholesalers, and the increase in competition for selling condoms resulting from acquired immune deficiency syndrome (AIDS). In addition, the CBD program had stagnated. Between 1984 and 1987, PROFAMILIA had carried out several operations research projects to test the cost-effectiveness of different nonclinical strategies. In 1987, PROFAMILIA transformed the two programs of CBD and CSM into a new approach called "community marketing." The 100 instructors employed in the CBD program became the sales force of the new program, and their role as promoters in the community declined. The costs of running the new program were reduced, while PROFAMILIA was able to maintain high sales and a major share in the market for both pills and condoms (Trías, 1992). At the same time, the income generated from local contraceptive sales became a much smaller proportion of PROFAMILIA's local income.

Mobile Services

In 1976, PROFAMILIA established mobile units at its centers so that the units could take sterilization to rural areas and remote parts of cities. Offering surgical procedures through mobile units was another pioneering strategy that extended PROFAMILIA's presence throughout the country. According to IPPF (1995),

Depending on the number of local clients and their distance from one of the association's centers, a mobile team would be deployed to provide services, or arrangements would be made to bring candidates for surgical contraception to the association's nearest center. The two alternatives enabled PROFAMILIA to achieve a better cost-benefit ratio while facilitating quality services in all of its facilities.

PROFAMILIA's mobile units brought family planning and gynecologic information and services not only to remote areas but also to parts of the country that are subject to guerrilla violence and to poverty-stricken areas that surround some of the big cities. In 1997, PROFAMILIA gave special emphasis to reaching those persons displaced by the guerrilla violence in rural areas. For the first time, it used some of the interest income generated by its endowment fund for this purpose. (See Section 3.2.5 on the endowment fund.)

Other Approaches

Of the various approaches in service delivery tried by PROFAMILIA, one component deals with reaching special population groups whether they were rural populations, in the case of the initial CBD program, or efforts to reach men and adolescents. The provision of vasectomy in 1970 was the beginning of PROFAMILIA's effort to serve the needs of males. After years of very modest results in male acceptance of vasectomy, PROFAMILIA opened two clinics in 1985 that were exclusively for men (in Bogotá and Medellín) and that were based on the success of PRO-PATER's male reproductive health clinic in São Paulo, Brazil. By 1990, the number of male clinics totaled ten and offered not only vasectomy, but also other family planning and reproductive health services for men.

Three clinics (those with a sufficiently large client base to justify the extra cost of separate services) had separate entrances and waiting areas for men. In Bogotá, the male clinic is housed in a separate building adjacent to the larger complex. The services have been advertised on the radio and television, although the latter is prohibitively expensive (AVSC and PROFAMILIA, 1997). Male acceptance of vasectomy through these clinics has increased sharply. An operations research study found that clients in exclusively male clinics were no more satisfied with the services they received than were clients in integrated clinics (Vernon et al, 1991). Having separate services can be useful but is not essential to reach men, although "paying attention to men's special needs also works to attract them" (Vernon et al., 1991). The male focus is likely to remain part of

PROFAMILIA's approach even if most male services are offered in the integrated clinic setting.

The opening of a center for adolescents in 1990 was another program innovation for PROFAMILIA. The adolescent centers, which now total seven in various Colombian cities, provide information and services on reproductive health to youth (boys and girls) ages 13 to 19. The model developed by PROFAMILIA for training and services through these centers is considered effective. (See Section 4.3) It is also recognized that adolescent services will never be self-sufficient, given the limited ability of these clients to pay.

Through two operations research projects, PROFAMILIA began AIDS prevention activities in an attempt to test the organization's ability to provide such information to the public and to provide condoms to vulnerable groups. Despite the organization's initial reluctance to address this problem area (because of concern that AIDS prevention activities might adversely affect family planning services and the perceptions about condoms and PROFAMILIA), the research showed that demand existed for information on AIDS among PROFAMILIA's traditional family planning audiences. As a result, awareness and prevention of the human immune deficiency virus (HIV) and of AIDS have become a part of the institution's information and education activities, especially for adolescents. Other HIV/AIDS outreach activities for special target groups were considered beyond the organization's mission and resources (Vernon et al., 1990).

The evolution in service delivery strategies at PROFAMILIA has run the gamut from a clinic-based program to one that added both community-based and commercial components, as well as mobile services. Given that family planning is generally very accessible and that the commercial sector is the predominant source of temporary methods, PROFAMILIA is once again emphasizing its clinic-based services.

3.2.2 Range of Contraceptive Methods

The increasing number of contraceptive methods that became available through PROFAMILIA is similar to the evolution in the variety of service delivery approaches. The gradual increase in available methods appears to have contributed to the ever-growing number of clients during the program's first 30 years.¹¹ The first methods provided by PROFAMILIA clinics were IUDs and pills. Vasectomy was first offered to men in 1971, followed by female sterilization (laparoscopy) in 1973 and minilaparotomy in 1974. Access to voluntary surgical contraception was extended through the mobile programs. Also through the CBD programs, rural promoters and urban instructors referred people to clinics for sterilization and IUDs. In 1988, PROFAMILIA began to provide vasectomy using a new no-scalpel technique.

With the advent of the rural and then the urban CBD programs, clients had increased access to pills, condoms, and spermicides. Offering pills through the CBD program and without medical supervision was controversial, but PROFAMILIA provided them because “at that time (a) excluding the IUD [which couldn't be provided without medical supervision, and medical personnel were very few in rural Colombia], the pill is the most effective means of birth control; (b) the risk it [the pill] carries is smaller than the risks of pregnancy and childbirth; and (c) any woman experiencing side effects can always be referred to a physician at the nearest PROFAMILIA clinic or health center” (Echeverry, 1975).

The CSM program also had an important, positive impact on the perception and use of condoms. Before this program, condoms were essentially sold under the counter, and their use was associated with prostitution. By working directly with the staffs of pharmacies and by using point-of-purchase advertising and information about materials, the CSM program helped to improve greatly the general perception of each condom brand's quality and acceptability (as an over-the-counter product) and of condoms' usefulness for family planning (Plata, 1997).

Following the pre-introduction trials of NORPLANT (see Section 2.3.4), PROFAMILIA conducted an acceptability study of the method in several of its clinics with support from the World Health Organization (WHO) in 1987. Then in 1991, PROFAMILIA trained personnel in all its clinics in the insertion, management, and removal of NORPLANT, as well as in counseling.

The availability of an increasing mix of family planning methods was very important in the development of family planning services in the 1970s and 1980s. As the overall level of contraceptive use rose nationally—and given the now predominant role of pharmacies as a

¹¹ Beginning in 1995, the average number of CYPs began to decline from 2.1 million in 1994 to 1.9 million in 1995 and to 1.7 million in 1996, because of various factors including changes brought about by Law 100 and by the increasing push at PROFAMILIA for self-sufficiency (discussed in Section 3.2.5).

source for pills, injectables, vaginal methods, and condoms—it should not be surprising that PROFAMILIA’s comparative advantage in family planning is in offering clinical methods, especially sterilization (male and female), implants, and IUDs.¹²

One important aspect of the variety of methods concerns the freedom to choose a method (Tamayo, 1978):

In providing family planning services, PROFAMILIA had to use every precaution to see that no element of coercion should intrude into them even indirectly. Family planning was originally justified as making real the exercise of an almost universally recognized human right, the right of people freely to choose the number and spacing of their children. In its pioneering situation, subject to constant attack, PROFAMILIA found all the more reason to maintain inviolate the principle of voluntary choice. The association has never used incentives to gain acceptors of contraceptive practice.

This principle is still very much a part of PROFAMILIA today because the vast majority of PROFAMILIA’s clients obtain their preferred method.¹³ This policy also attests to the organization’s appreciation that continuation rates improve when clients receive their preferred method (Murphy, 1996).

3.2.3 Changing Role of Providers

PROFAMILIA was a pathfinder in Colombia for changing the roles of some providers of family planning services. Through the combined positions of the founder, key executive staff members, and clinic directors, the organization had sufficient technical competence, understanding of the relative risks of pregnancy versus contraception, and exposure to programs in other countries to try out new approaches for providing particular contraceptive methods.

The first such innovation involved the promoters in PROFAMILIA’s rural CBD program. These nonmedical community workers were permitted to provide oral contraceptives to women without a medical prescription. PROFAMILIA’s new practice was the usual practice of Colombian pharmacies of providing various medications including oral contraceptives without prescription (Echeverry, 1991). (See section 3.2.2 for the rationale.) This innovation was initially opposed by IPPF’s association directors in the Western Hemisphere Region when the Colombian CBD program was presented in 1973. Thanks in part to the crucial support of Dr. Benjamin Viel, then–Regional Executive

¹² Until 1997, PROFAMILIA did not provide injectables, but Cyclofem (a monthly injectable developed by WHO) is now available.

¹³ PROFAMILIA routinely collects information from clients on their desired method and on the method they actually receive. This information is presented in the organization’s regular reports of service statistics. (For example, see Ojeda (1997) and Tables 8 and 9 in Chapter 6.)

Director of IPPF, the practice of providing pills through a community-based program became acceptable and standard.

The second innovation involved having paramedical personnel (i.e., nurses) provide contraceptive services in Colombia beginning in 1972. This was not the first such use of paramedical personnel in the region. In 1965, a training program in Barbados involved nurse-midwives who inserted IUDs and took smears in cervical cytology with good results (Cummins and Vaillant, 1966). The advisability of the enhanced role given to nurses by PROFAMILIA was confirmed in a study that showed those nurses were as effective in providing such services (including IUDs) as were physicians (PROFAMILIA, 1978).¹⁴ Fortunately for PROFAMILIA, delegating medical functions to paramedical personnel was not prohibited by Colombian law (IPPF, 1980). MOH programs may have benefited from PROFAMILIA's lead in such areas because the enhanced role of nurses in service provision was also adopted by the MOH in the 1970s. (See Section 4.2.)

3.2.4 Contraceptive Commodities

Contraceptive logistics and commodities are essential components of any effective family planning program. Contraceptives must be obtainable and must be readily accessible to users at reasonable prices. To ensure a supply of contraceptive commodities, family planning programs may find themselves involved in various functions including importation, transport, storage, and sales. Since the initiation of family planning programs in Colombia, obtaining contraceptive and other necessary commodities has not been a problem. The contraceptive pill has always been easily available. The pharmaceutical laboratories in Colombia first imported pills and then started manufacturing them locally. The laboratories were able to import the necessary raw materials without problems and to locally produce both pills and injectables.

Initially, PROFAMILIA entered the commodity business to ensure its own supply of contraceptives. This role evolved because there was no adequate system for marketing pills through the pharmacies, and PROFAMILIA then became a supplier of commodities to other entities through its CSM program. The commodity side of the CSM program deserves special attention. Under this program, PROFAMILIA negotiated independent contracts with Schering Laboratories of Germany and Wyeth of the United States to purchase a large quantity of oral contraceptives at the same prices given to international agencies. PROFAMILIA distributed these contraceptives through the official pharmaceutical market and established its own distribution network in rural areas and marginal zones of large cities. Through this mechanism, up to 5 million cycles of pills were distributed per year, thereby increasing public access to such products. However, the most significant effect of the program was keeping contraceptive prices low because of PROFAMILIA's social rather than financial interest. PROFAMILIA's CSM program was

¹⁴ In the mid-1970s, PROFAMILIA established Latin America's first training center for paramedical personnel in Bogotá as a result of its experience in the use of paramedical personnel. Unfortunately, the regional training center could not be sustained after donor funding ended.

sufficiently influential to dissuade other actors from raising the prices of their own products significantly.

For many years, PROFAMILIA was the principal importer of condoms, which are traditionally used by a small percentage of Colombians. With the advent of the AIDS virus, the commercial market for condoms expanded. As commercial agents increasingly provided pills and condoms, PROFAMILIA's market share declined, costs increased, profits declined, and eventually losses were incurred. The directors of PROFAMILIA decided that it was time to yield to the commercial sector the role of supplying pills and condoms. Thus after many years, Schering and PROFAMILIA ended their relationship in 1997. PROFAMILIA is initiating the distribution of contraceptives from other pharmaceutical laboratories with brands that are less well known in the Colombian market.

Over the years, PROFAMILIA has also ensured a significant and constant flow of other contraceptive commodities such as the IUD (first the Lippes Loop and later the Copper "T" [CuT] 80A) to support its programs and to stock other entities. PROFAMILIA and SOMEFA maintain similar systems for supplying IUDs and NORPLANT to public and private entities, as well as to private physicians. The contraceptive supply systems ensure that all actors who wish to offer services related to contraception will have access to the latest methods and technologies. Because the commercial sector has not been interested in importing contraceptive commodities such as IUDs or implants, the contraceptive supply systems have also helped maintain a low cost for selling those methods.

In the future, PROFAMILIA plans to continue a number of contraceptive supply functions such as supplying, along with SOMEFA, the IUD and vaginal methods (methods of limited demand in Colombia), the methods that have low utility margins (such as NORPLANT), or the new methods that lack an established demand. Because of the lack of suppliers with an ample delivery network, PROFAMILIA will continue to import and to provide replacements to maintain laparoscopic equipment.

Colombia's experience suggests that the role of a private family planning institution (e.g., PROFAMILIA) in marketing, distributing, and selling contraceptives such as pills and condoms will diminish as the program matures and as the overall market for these commodities grows. Many of these functions are eventually performed by specialized, commercial firms that enjoy a greater capacity in this area and that make the family planning institution's role redundant.

3.2.5 Cost Recovery and Sustainability

PROFAMILIA is heralded as a model for its experiences in the areas of cost-recovery, cost-effectiveness, and sustainability. The push for sustainability is altering the organization in profound ways, especially in terms of its ability to fulfill its basic mission. At the same time, changes in the general health care environment are influencing PROFAMILIA's role in family planning in Colombia.

Fee for Services

From its inception, PROFAMILIA has maintained a general policy that clients benefiting from the program should contribute something, however little, for the service. This policy is based on three principles. First, people would value a service for which they had to pay a fee. Second, there would be no question of people's voluntary acceptance of family planning because all persons seeking services would be charged for them. Third, services should generate income because the organization would have to become self-sufficient at some time in the future (Tamayo, 1978, 1989; Trías, 1992).

Selling services and contraceptive supplies has indeed been a hallmark of PROFAMILIA's program. It has been standard practice not only in the clinic-based and social marketing programs but also in the rural CBD program. For example, a cycle of pills cost four Colombian pesos (US\$0.16) in 1974. Although the price was much lower than the commercial price at that time, the fee helped to pay rural distributors for their services: half the price was kept by the rural contraceptive distributor. Similarly, the distributors in the urban CBD program received a commission, which in 1979 averaged about one-third of the sales price of the pills and condoms provided by PROFAMILIA (IPPF, 1979).

The strategy used in setting the fees was based on three factors: (a) that PROFAMILIA was not to lose money in providing the service, (b) that charging for methods would help eliminate the loss of supplies because distributors had to pay for them,¹⁵ and (c) that potential acceptors would not be prevented from practicing family planning for economic reasons. Historically, PROFAMILIA has tended to err on the side of the acceptor: "It is better to lose money than acceptors" (Trías, 1989). According to Tamayo (1989), PROFAMILIA had in effect "a sliding price system where clients are often charged according to ability to pay. The actual price is determined by the PROFAMILIA counselor, based on what the client says she or he can pay and on the counselor's intuition."

In the program's early years, fees were set low enough so that all users could pay and thus the contribution to cost recovery was minimal. During the 1980s, PROFAMILIA carried out a study to determine the cost of female sterilization. The average cost was estimated at US\$35. This study led to other such studies and helped to rationalize the fee levels. In

¹⁵ Distributors typically bought only the quantity that they thought they could sell.

more recent times, as fees for services are raised to keep up with inflation, the usual practice has been to make small adjustments gradually, three or four times a year, rather than one large annual increase. Clients do not seem to notice the gradual increases (Trías, 1992). Especially since the end of USAID support, PROFAMILIA has also gradually increased its fees for family planning services. All clinics have service fees clearly posted. The only exception is the fee for a sterilization procedure because this service is still negotiated on the basis of one's ability to pay. The posted fees for services in the youth centers are discounted somewhat, given adolescents' more limited economic resources. Even with recent fee increases, PROFAMILIA's prices were still very reasonable. As of June 1997, the cost to a PROFAMILIA client for a general medical or family planning visit was a little less than US\$8. By contrast, a visit to a private physician in Bogotá costs between US\$40 and US\$60, although under Law 100 private practice becomes rarer because more clients now prefer to go through their health insurance organization (AVSC and PROFAMILIA, 1997).

The impact of the gradual increase in fees is seen in the profile of PROFAMILIA's clientele for family planning. There has been a shift to a more middle-class population as measured by level of education and by the socioeconomic status (percentage of households with unsatisfied basic needs),¹⁶ although the news is not all bad as shown in Tables 5a and 5b. The percentage of clients of the clinical program with secondary or higher education increased from about 66 percent in 1986 to almost 77 percent in 1996. While this change has occurred, the percentage of clients with no education (albeit a very small proportion) more than doubled between 1991 and 1996. For PROFAMILIA's sterilization program, the majority of clients (54 percent) have only primary or no education, but here there has also been a shift. These trends are supported by those shown in Graph 2 where the percentage of clients with unsatisfied basic needs has declined from 30 percent to about 13 percent between 1989 and 1996. When PROFAMILIA clients are compared to those in all households (according to 1990 and 1995 national surveys), PROFAMILIA served a group of clients less well-off than the average in 1989, but it was serving a better-off group of clients by 1996. The push for sustainability has clearly affected the type of clients that PROFAMILIA is reaching.

¹⁶ PROFAMILIA calculates this index by using the following measures: houses without plumbing, a toilet, or electricity, and with the head of household having fewer than three years of school.

Table 5a

**Trends in Education of Clients of PROFAMILIA's Clinical Program,^a
Selected Years, 1976–1996**

LEVEL OF EDUCATION	1976	1986	1991	1996
None	5.25	1.5	1.1	2.7
Primary	54.7	32.2	25.7	20.4
Secondary	37.5	56.3	61.6	62.4
College	2.6	9.8	11.6	14.4
Total	100%	100%	100%	100%

Source: PROFAMILIA, Table 3, February 1997.

^a Clients include new users of temporary methods such as the IUD, pill, NORPLANT, and others.

Table 5b

**Trends in Education of Clients of PROFAMILIA's Surgical Program,^b
Selected Years, 1976–1996**

LEVEL OF EDUCATION	1976	1986	1991	1996
None	12.7	11.3	6.9	5.5
Primary	67.2	58.5	54.6	48.5
Secondary	19.2	27.5	35.7	42.1
College	0.9	2.5	2.9	3.9
Total	100%	100%	100%	100%

Source: PROFAMILIA, Table 22, February 1997.

^b Clients include users of sterilization.

Graph 2 available in hard copy

Cost-Effectiveness

Over time, PROFAMILIA added to its initial focus on program efficacy (delivering services of adequate quality and quantity) by looking at issues of program efficiency (delivering services at the lowest cost) and self-sufficiency (Trías, 1984). In the early 1970s, several studies of program costs and of costs per client or per acceptor contributed to PROFAMILIA's developing a long-standing interest in assessing the cost-effectiveness of its different service delivery strategies. These various studies have helped PROFAMILIA emphasize strategies with lower costs such as converting the CBD program into social marketing. One study (Trías and Ojeda, 1978) found an average cost of US\$3.40 to provide a couple with a year of contraceptive protection, although the cost by type of service delivery varied from US\$0.43 to US\$12.24 (Alan Guttmacher Institute, 1979). A later study that compared the CSM and CBD systems in terms of cost-effectiveness found that CSM was the only strategy tested that made a net profit (US\$1.18 per CYP), largely because of the lower operating costs of CSM (Vernon et al., 1988). Despite the results and because of problems with government controls on the price and sale of contraceptives that made the CSM unprofitable, the community marketing program emerged and replaced the CSM program. (See Section 3.2.1.)

By the early 1980s, PROFAMILIA's internal financial statements contained detailed information on the unit cost per CYP by method, clinic, and program. Further, the accounting system initiated the concept of cost centers as a way to track costs by program and clinic. Having a simple, timely financial information system has contributed to informed and efficient decision making by PROFAMILIA's program and clinic managers (Tamayo, 1989).

Diversified Services

PROFAMILIA's interest in diversified services has been based on two rationales: (a) serving clients' needs, and (b) generating income to help subsidize family planning services. Its one foray into integrated services was apparently successful but rather short-lived because it depended on outside funding.¹⁷ Almost from its inception, PROFAMILIA has provided other reproductive health services in addition to family planning. Given the organization's preoccupation with clients' needs, it was logical that the first PROFAMILIA clinics offered cervical cancer screening for women as early as 1967 (Galvis, 1995).

¹⁷ With funding from the Japanese Organization for International Cooperation in Family Planning (JOICFP), PROFAMILIA carried out an experiment in integrated services as it combined family planning with intestinal parasite control in the late 1970s through its CBD program. Many aspects of the experiment were positive (e.g., CBD distributors found that (a) integration helped enhance their reputation of being concerned with general family welfare, (b) it increased sales of contraceptives, and (c) it raised the general level of health awareness. The integrated program lasted about four years, but it ended when the external funding stopped (Echeverry, 1991; IPPF, 1980).

With the push toward sustainability in the mid-1980s, PROFAMILIA began a concerted effort to diversify its services. The purpose of diversification was to generate funds to subsidize family planning services for those who could not pay. Fees charged for diversified services are generally cheaper than they would be at other private institutions, but are higher than actual costs to deliver the services. Thus PROFAMILIA is able to generate a substantial amount of money (Trías, 1992).¹⁸ Most of the diversified services are associated with reproductive health: gynecology, urology, pap smears, pregnancy tests, infertility, and venereology. Other services include general practice, pediatrics, and even dentistry, in addition to various minor surgical procedures that can be managed on an outpatient or short-stay basis. With some new services such as gynecology or pregnancy tests, PROFAMILIA has been able to make better use of its existing facilities and staff members. For other services, additional investments in personnel and equipment have been needed.

In some cases, PROFAMILIA has set up joint ventures with specialists (e.g., dentists or radiologists for mammography) so that its own staff members are not actually providing services, but the services are provided at its clinics. The specialists provide the necessary equipment and their time. PROFAMILIA covers administrative and indirect costs including education, information, auxiliary staff, and client management. The income from these specialized services is shared (sometimes 50/50). PROFAMILIA collects the income from clients, then pays the service provider, and all parties benefit from these arrangements, including the client. Through the USAID-IPPF/WHR Transition Project, a major portion of USAID assistance supported expansion of the diversified services (See Section 5.2.1).

In addition to providing health services, PROFAMILIA began offering legal services in 1987. Ten years later, these services are available at six of its centers. Counselors promote and defend women's rights according to the legal framework in the 1991 Colombian Constitution. They advise women about their rights in terms of family law and of countering various forms of discrimination. In Bogotá, the legal office has a criminal law program that deals with domestic violence, as well as with child support cases. One interesting aspect of this work has been PROFAMILIA's role in promoting reproductive health and rights. PROFAMILIA's staff members were very active at international conferences held in Cairo in 1994 and in Beijing in 1995, and they participated in drafting key conference documents.

In 1992, the range of services offered through PROFAMILIA's mobile programs was expanded to include reproductive health services such as temporary methods of family planning; cervical and uterine cytology; gynecological, prenatal, and infertility consultations; and pregnancy testing. The expansion and the diversification of services have improved the recovery of program costs from about 50 percent, when services were entirely surgical, to 85 percent (IPPF, 1995).

¹⁸ Along with diversifying the types of services delivered, PROFAMILIA looked for ways to improve quality of services. For example, clinic hours were extended through the lunch hour to accommodate clients' work schedules (IPPF, 1994).

Cost Reduction and Other Efficiencies

One component of efficiency is reducing costs. Historically, PROFAMILIA has made various efforts to cut costs even when the cut was painful. For example, promoters working in the rural CBD program were transferred from well-established zones to new areas, and their numbers were cut from 98 to 65 between 1977 and 1979 as a cost-saving measure. Along with the reduction in personnel was an 11 percent drop in acceptance levels that “PROFAMILIA regarded...as tolerable when set against the cost savings” (IPPF, 1980). During 1997 with the end of USAID funding and with a decline in core support from IPPF, PROFAMILIA was especially diligent in looking for ways to cut costs. Personnel costs have been reduced by about US\$1 million a year through an 8 percent reduction in staff. Five “redundant” clinics have been closed, although care was taken to ensure that clients served by these clinics would still have access to services. (See Section 3.2.1.) Finally, some of the mobile units have been discontinued.

PROFAMILIA has taken additional steps to improve the organization’s management and efficiency. Traditionally, well-known and prestigious medical physicians from a given city were hired as clinic directors, their outstanding reputations helping to establish the new services in family planning. Increasingly under Law 100, health organizations need directors with strong management skills. PROFAMILIA is appointing clinic directors who have been trained in program administration, many of whom are also physicians. Nearly 40 percent (14 of 36 clinic directors) have such training. PROFAMILIA has also invested in improving its computer systems to streamline various administrative tasks.

Contracts for Family Planning and Health Services under Law 100

As discussed in Section 7.1, the 1993 Law 100 has dramatically altered the world of health care in Colombia. For PROFAMILIA, this law has two consequences: (a) increased opportunities to sell its services to a range of health insurers and intermediaries for health services, and (b) more competition from other service providers in family planning, which has been PROFAMILIA’s predominant domain for many years. At this early stage in implementing Law 100, it is difficult to say what health care will look like in Colombia in another 5–10 years. Even so, PROFAMILIA has lost no time in taking advantage of the opportunities to provide services to a wide range of public and private health entities. In fact, the number of such contracts increased from 17 in 1996 to more than 150 in 1997. The number of PROFAMILIA clinics that are engaging in this new business also increased from 9 in 1996 to 29 (80 percent of all clinics) in 1997. The types of entities with whom PROFAMILIA has contracted include *Entidades Promotoras de Salud (EPS)* (or health insurance organizations similar to Blue Cross and Blue Shield in the United States), and *Administradoras del Regimen Subsidiado (ARS)* (or health insurance organizations for those individuals who cannot pay for health insurance).

In addition, PROFAMILIA now has 40 contracts with different social security organizations. About half the value of PROFAMILIA’s contracts are with social security

organizations and the other half are with EPS and ARS entities. The following are examples of the contracts with social security organizations:

- The Social Security Institute/*Instituto de Seguridad Social* (ISS) has hired PROFAMILIA to provide general health services in addition to sexual and reproductive health and family planning. These services include female sterilization for which the fee charged is above PROFAMILIA's costs. The value of these contracts between January 1 and September 5, 1997, was US\$4.2 million.
- The ISS's regional program in Medellín hired PROFAMILIA to carry out promotion and prevention activities in health for a value of US\$1 million.
- PROFAMILIA was hired along with the Health District Secretariat to train hospital personnel in Bogotá through a contract worth US\$250,000.

The number of contracts with other entities in social security is rising and is expected to increase in 1998. The mayors throughout the country will change in 1998, which may create another opportunity for PROFAMILIA to increase the number of contracts for rendering services. Over the longer run, it is likely that the number of contracts may decline, given the practical difficulties of managing a huge number of contracts. In addition, there may very well be other shifts in the health market as stronger groups assume a larger role and as weaker service providers drop out of the competition.

Endowment Fund

Thanks to a US\$6 million donation from USAID, PROFAMILIA has an endowment fund. The fund was designed as the final donation from USAID through IPPF/WHO's Transition Project in a carefully planned strategy to increase the organization's tax-free sustainability. A separate corporation, the Fund for Family Planning in Latin America, was set up in the United States as the institutional basis for this fund. At present, only the endowment for Colombia exists under this corporation. The value of the fund had increased to more than US\$9.2 million by June 1997 because of historic gains in the U.S. stock market. The estimated annual level of interest income from the fund's diversified portfolio is nearly US\$250,000, or about 2.7 percent (Brown Brothers Harriman & Co., 1997).

PROFAMILIA's endowment fund was USAID's first experience in setting up such a fund in the population sector. Donating money for an endowment fund is a conservative way to invest. Given the size of PROFAMILIA's annual budget (about US\$24 million), the annual income from the fund is actually a very small percentage of the operating budget. The donation to the endowment fund might have been more productive if it had been used in other ways such as for additional upgrading of facilities. However, it serves as an important long-term financial cushion and allows the organization to support a number of critical and emergency services for the poor that it otherwise could not carry out, given the need to become fully sustainable.

In accordance with the agreement between USAID and PROFAMILIA, during the first three years no funds were spent from the endowment's principal or interest in order to let the fund's worth appreciate. PROFAMILIA waited until September 1997 to request its first draw (US\$350,000) on these funds. About 70 percent of this money will be used to subsidize family planning services at seven PROFAMILIA centers serving people displaced by current violence in Colombia and at three centers in very poor areas. The remaining 30 percent will be used to remodel several clinics.

Sustainability

Through its user fees, product sales, diversification of services, and contracts for family planning and health services, PROFAMILIA has gradually increased the level of financial self-sufficiency. As shown in Table 6, PROFAMILIA moved from being 40 percent self-sufficient in 1980, to 58 percent in 1990, and to 72 percent in 1996. For the first eight months of 1997, PROFAMILIA achieved about 86 percent self-sufficiency. These are impressive changes in a relatively short time.

Table 6

**Percentage Distribution of PROFAMILIA's Income and
Expenditures by Type, Selected Years, 1973–1997^a**

Income	1973	1980	1986	1990	1996	1997^b
Donations ^c	88%	58%	61%	49%	26%	12%
Sales ^d	0	15	9	9	9	7
Medical ^e	0	19	22	29	57	66
Other ^f	0	8	8	13	8	15
Total as % of Income	—	100	100	100	100	100
Total in US\$ millions	\$1,819	\$4,819	\$7,216	\$9,379	\$22,791	\$17,133
Expenditures						
Clinics, labs, surgery	—	60%	64%	59%	63%	61%
CBD	—	25	15	—	—	—
CSM	—	—	1	11	4	6
IEC	—	3	—	—	6	5
Rural	—	—	—	—	1	1
Youth Center	—	—	—	<1	3	3
Legal Program	—	—	—	<1	1	1
M,E,&R ^g	—	2	3	4	3	3
Administration ^h	—	15	13	13	22	22
Total as % of Income	89%	105%	96%	89%	103%	102%
Total in US\$ millions	\$1,624	\$5,072	\$6,929	\$8,332	\$23,557	\$17,537
Surplus (Deficit) in US\$ millions	\$195	(\$253)	(\$287)	\$1,047	(\$766)	(\$404)

^a See Table 5A in Appendix F for a more detailed breakdown of income and expenditures.

^b Figures for 1997 are through August 31, 1997.

^c Donations include national and international cash, national and international in-kind, and contraceptives.

^d Sales include over-the-counter sales at clinics, sales from the Social Marketing and CBD programs, less discounted/returned products.

^e Medical income includes that from clinics, laboratories, and surgical procedures.

^f Other includes income from investments, rental, contracts, etc.

^g M,E,&R includes monitoring, evaluation, and research studies.

^h Administration includes management, finance, administration, systems, institutional promotion, training, and infrastructure.

A 1991 study showed that family planning services were about 28 percent self-sufficient while diversified services were 276 percent self-sufficient (PROFAMILIA and IPPF, 1993.) According to data from 1997, family planning was about 65 percent self-sufficient

(US\$2.2 million in income versus US\$3.4 million in costs), while sexual and reproductive health services were 161 percent self-sufficient (US\$7.1 million in income versus US\$4.4 million in costs) (PROFAMILIA and Macro, 1997). The reasons for changes in the levels of self-sufficiency by different program areas are: (a) PROFAMILIA's contracts with ISS and the EPSs that allow it to charge the full cost of providing family planning services, and (b) an improved accounting system that allows PROFAMILIA to apportion more indirect costs to the costs of providing diversified services.

Looking at just the clinics for men, we see that charging for more diversified services has increased self-sufficiency dramatically. In 1986, the male clinic in Bogotá covered 70 percent of its costs through fees for services. In 1995, the clinic was 121 percent self-sufficient, thus making a profit. The male clinics in Medellín and Cali were also self-sufficient (AVSC and PROFAMILIA, 1997).

The relative contribution of PROFAMILIA's different programs to the organization's income has changed over the years as various service delivery strategies have evolved. In 1980, fees from medical, laboratory, and surgical services (i.e., medical income) accounted for about 44 percent of PROFAMILIA's local income (or about 19 percent of total income including donations). This figure was followed by sales from social marketing (36 percent) and by other income including investments, rentals, and contracts (20 percent). As mentioned earlier, income from the CSM program was important to help subsidize the CBD program for a number of years. As the share of sales from the social marketing program has declined (as more Colombians get their temporary methods from pharmacies whose contraceptives are not supplied by PROFAMILIA), fees from medical and surgical services have become increasingly important, reaching 75 percent of local income in 1997, or 66 percent of total income. This increase was largely because of the concerted and successful effort to diversify its services into the broader arena of reproductive health and even more general health services.

Looking at the trends in terms of actual U.S. dollar amounts, we see the increase in medical income has been phenomenal: from under US\$1 million in 1980, to US\$2.5 million in 1990, and finally to an estimated US\$17 million for 1997.¹⁹ Despite the decline in the proportion of funds from product sales, there has been a healthy increase in absolute income until 1997. Very promising growth is seen in the income from contracts, thanks to Law 100. PROFAMILIA has been characteristically aggressive and innovative in its approach to achieving self-sufficiency. The various strategies of diversification and seeking of contracts for health services under Law 100 have enabled the organization to reach an impressive level of sustainability.

¹⁹ This is based on an annualized estimate of income from the first eight months of 1997.

3.3 Conclusion

For many years, PROFAMILIA has been the indisputable leader in the supply of clinical methods. It has had sufficient strength in the market to ensure the provision of modern methods such as pills, vaginal methods, and condoms, and it has made sure that costs for these are affordable to those with a low income. PROFAMILIA also established the most comprehensive programs to educate and inform the community. Thanks to these programs—which reached all regions of the country, were professionally developed, and respected local customs—much of the population came to know of and use contraceptive methods. Today, knowledge of what the methods are and of where to obtain them is almost universal in Colombian society. As an institution, PROFAMILIA has always assessed the usefulness of existing approaches and strategies and tested new approaches while looking for greater effectiveness and efficiency. It has been able to abandon strategies when they were no longer useful and productive.

4. FAMILY PLANNING AND POPULATION ACTIVITIES IN THE PUBLIC SECTOR

This section reviews the role of the public sector in developing Colombia's family planning and population activities. It also presents examples of the collaboration between the public and private sectors that forms part of the story of family planning in Colombia. Initially, teaching hospitals (principally through ASCOFAME) played a very critical role. Subsequently, the Ministry of Health's MCH program was charged with developing a program in family planning within the context of maternal and child health. Over the years, interest in developing population and sex education programs has invariably involved government agencies as well as nongovernmental organizations.

4.1 The Role of Teaching Hospitals

University hospitals in Colombia generally belong to the public health system, and through contracts with schools of medicine, they permit students from some universities to practice with them. Very few medical schools have their own hospitals. In the late 1960s and early 1970s, university hospitals played an important role in developing family planning programs. At that time, seven medical schools were affiliated with ASCOFAME. University hospitals served as the initial sites for service programs, trained personnel to manage the introduction of contraceptive technology, and carried out research. One of ASCOFAME's most successful endeavors in family planning was the postpartum program financed by the Population Council: it involved 29 hospitals across the country.

In 1972, the deans of the medical schools curtailed most of the family planning activities and population research. (See Section 2.2.2.) As mentioned earlier, responsibility for the family planning programs was then transferred to the MOH's MCH Division. Family planning programs were also dismantled in the university hospitals, and contraceptive methodology ceased to be taught in medical schools. For the next two decades, medical students in Colombia received no training in the use of contraceptives. This absence of training in medical schools represented a great cost to family planning in Colombia for two reasons: (a) the lost opportunities to provide services to the most needy, and (b) the cost to family planning service delivery programs of training health personnel. The lost opportunity in family planning was particularly significant because all recent graduates from medical school are required, under Colombian law, to perform one year of service in a remote rural area. In those remote areas, services are least accessible and the need for family planning methods is greatest. Without training in contraceptive methods, most of these physicians were unable to offer the services needed by the communities.

In the 1990s, some schools of medicine began to reintroduce contraceptive training in obstetrics and gynecology lectures and in programs of community medicine. At the beginning of 1995, AVSC International organized three meetings with schools of medicine and nursing from across the country so they could identify obstacles to reinitiating this

training. It was generally found that most schools of nursing had satisfactory maternal and child plus family planning courses at both the theoretical and practical levels. Nurses completed their training with sufficient knowledge to manage and supervise use of all temporary methods. In contrast, medical students received practically no training in these matters. Unfortunately, a follow-up of this activity has not been performed so we do not know if medical students are now receiving comparable courses. However, some professors of medicine reported that the medical curriculum is being revised and that instruction in family planning for medical students is improving.

The program of the Maternal and Infant Institute/*Instituto Materno Infantil*, a private hospital in Bogotá, deserves mention because it is responsible for lectures in obstetrics and gynecology for the Faculty of Medicine of the National University of Colombia. (This university led the student revolt against family planning programs and, as a consequence, severed its affiliation with ASCOFAME.) The Maternal and Infant Institute has established a family planning program that offers through its hospital services all the available contraceptive methods in Colombia, including female sterilization (tubal ligation), vasectomy, and NORPLANT. The program is open to the entire population of Bogotá, although women with complications from childbirth or abortion generally seek hospital assistance. The program also trains interns, residents, and medical and nursing students, while the hospital serves as a training resource for physicians and nurses from other hospitals in Bogotá and in the rest of the country.

Because of its important position in the fields of obstetrics and gynecology in Colombia, the Maternal and Infant Institute has become an effective demonstration center. Further, the Institute has shown that it is possible to provide family planning services, despite the norms and constraints of hospitals, without creating problems with the university, hospital directors, or students. This hospital relies on an efficient educational and informational program for potential users. It offers counseling and methods for interval, postpartum, and postabortion services. Two strong features of the Institute's program are immediate postpartum IUD insertion and tubal ligation.

4.2 Maternal and Child Health in the Ministry of Health

When the MOH assumed responsibility for family planning activities from ASCOFAME in the early 1970s, the programs were converted from vertical to integrated activities under the recently created MCH Division. The division developed three programs: (a) a program for children, (b) a maternal program, and (c) a population dynamics program that was in charge of family planning activities. The health rationale for family planning was clear from the start. Family planning services were a means of reducing maternal mortality and abortion (two closely related problems), and they would contribute to lowering infant mortality associated with high parity and short-birth intervals.

During the 1970s and early 1980s, the MCH Division developed and implemented a model for classifying obstetrical risk in women of reproductive age. The reproductive risk factors were (a) a woman's age (younger than 20 and older than 34), (b) parity (more than four

pregnancies), and (c) short-birth intervals (less than 24 months). Other socioeconomic variables had a relatively lower importance in the model. Every woman who sought contraceptive services from the MCH had to be classified according to her reproductive risk. This model for screening women by risk factors provided the MOH's family planning program with a strong health rationale, affording it an acceptable defense in public debates as well as in educational campaigns and community information.

Although the MOH has generally never been the predominant provider of family planning services, its contribution has certainly been important. The relative proportion of Colombians receiving services from the MOH has varied considerably from 27 percent in 1978, to 34 percent in 1980, to 15 percent in 1986, and finally to 27 percent in 1995. These fluctuations may reflect real variations, but they may also reflect the fact that women surveyed in the various national fertility surveys had difficulty correctly identifying the source of their family planning services. For example, women may have reported receiving services from PROFAMILIA when such services were, in fact, given by government hospitals that used promotional materials from PROFAMILIA. Some Colombians apparently believe that PROFAMILIA is an official government service, so the MOH's role in service provision may have been overestimated in the surveys. The problem of correct attribution is further complicated because the MOH's system for service statistics has traditionally been very weak, and family planning was not uniformly captured in the official registration system.

The MOH's family planning efforts have had several important characteristics. First, and as is typical for an MOH, the coverage of the MCH program was national, given that health centers and posts are disbursed throughout the country. Second, officials in charge of the MCH Division at the central level formed a strong multidisciplinary team of professionals and as such their work served as a good model for the rest of the MOH. Third, the MOH's health promoters were effective in extending services into the rural areas. In fact, the MOH allowed these rural health promoters to provide pills and condoms and to make referrals for sterilization and IUDs after a study in 1979–1981 tested the effectiveness of such a strategy. In all likelihood, this innovation followed PROFAMILIA's lead but was an indication that the MOH was willing to try new ways and to use research to test their effectiveness. Sometime later in a similar fashion, the MOH enhanced the role of nurses in family planning by allowing them to insert IUDs. The incorporation of family planning services into the MCH Division also helped to strengthen the systems for supervision and record keeping, and it generally increased the importance of MCH within the public health system. Finally, the MOH prepared and published the first technical administrative norms on family planning in 1984. These norms strengthened the MOH program and facilitated the provision of family planning services, which were recognized as part of basic health care.

As is more fully discussed in Section 6.2, the MOH's family planning program counted on the support of international donors and technical assistance agencies, as did PROFAMILIA. This support was critical for setting up the MCH Division as well as the training programs for the Division's personnel at both the national and departmental levels. Part of these resources paid for physicians who worked extra hours providing

family planning in hospitals and health stations of the public health system. Some observers think these payments contributed to establishing and reinforcing the program. Others disagree; they think that physicians who were truly interested did not need an incentive to offer these new services, and that those who were not interested took the money but did not do the extra work. In any case, the result was that the payments reinforced an impression of a special service that was not integrated with the rest of the health program. The payments were canceled in the first two years because of a lack of funds and because of the problems they generated.

Over the years, the MOH has received donations of contraceptive commodities (primarily pills, IUDs, and condoms) from various international agencies. To a lesser extent, it has used its own resources to purchase contraceptives, but the MOH has never played an important role in this area. Commodity distribution through the MOH's network of health facilities had various problems: (a) a very unequal distribution with an excess in some places and with stock outs in others; (b) frequent changes in the brand and packaging of contraceptives, causing women to abandon the method (especially pills); (c) lack of contraceptives in health facilities, which discouraged both potential users and health personnel who promote methods; and (d) a system that was not well managed and supplies that were frequently inadequate, although the same products were later found for sale on the local market.

In the mid-1970s, the MOH stopped providing drugs and other provisions for hospitals and health centers. The MOH authorized each health service to establish its individual purchase and distribution channel in accordance with its own capacity and needs. Unfortunately, contraceptives were not included in this decentralization, and they continued to be managed centrally with poor results. However, beginning in 1994, the MOH turned over the procurement and distribution of contraceptives to the individual health services or hospitals and clinics. In retrospect, the lack of an adequate and reliable logistics system for contraceptive commodities is probably the most important reason that public sector programs did not develop to their full potential.

Two political developments of the 1990s (reviewed in Sections 2.2.1 and 7.1 of this report) gave the MOH a new and stronger policy basis for delivering family planning services. The 1991 Colombian Constitution recognizes a series of fundamental, individual rights including the freedom to decide on the number and spacing of one's children. This constitutional principle was not implemented immediately but was included in the 1993 reform in the social security system, Law 100. (See Section 7.1.)

Although it is difficult to document the precise role of the MOH in the family planning story, those involved in or close to the MOH's program over the years attest to two important contributions. First, the incorporation of family planning into the MCH program made the MCH services more effective (in large part because of the considerable training and technical assistance received). Second, a significant proportion of Colombians received family planning services from the MOH, making the Ministry an important actor in the family planning story.

4.3 Government Programs in Population and Sex Education

Concern about problems of adolescents—including high teenage pregnancy rates—on the part of a number of Colombian health and education professionals resulted in efforts to develop programs in population and sex education. Beginning in the late 1970s, several nongovernmental organizations (NGOs), including the Regional Committee for Sex Education in Latin America and the Caribbean-Colombia (CRESALC), the *Fundación para la Orientación Familiar* (FUNOF), and ACEP, carried out pioneering activities to develop sex education curricula under diverse names such as human sexuality, education for family life, and responsible parenthood. These activities, however worthwhile, generally suffered from their small scale and low coverage, their high dependency on external funding, and their lack of evaluation to show results or impact. In addition to promoting curriculum development, the NGOs made a concerted effort to convince government officials that sex education should be adopted as an official program. Unfortunately, during the 1970s and part of the 1980s, opposition forces including the Catholic Church successfully blocked these efforts.

Since the late 1980s, the Ministry of Education has been engaged in various activities that should in theory have led to the incorporation of “population education” into its formal and informal educational programs. The principal themes of population education in Colombia are the following: population and development; sexual and reproductive health; gender equality; and the body, the family, and the community (UNFPA, 1997). With UNFPA support from 1989 to 1996, this effort produced and tested training and curriculum materials that have been used for grades 2–5 in 10 of Colombia’s 32 departments. Despite the passing of about nine years, the ultimate audience of students has not been reached, most groups in the education sector are not aware of the concept nor the need for population education, and apparently no attempt has been made to reach out-of-school youth or the rural population (Corona et al., 1996).

Under the Gaviria Administration (1990–1994), the Ministry of Education launched a national project for sex education (Resolution 03353 of 1993), included “sex education” in the General Law for Education (Law 115), and emphasized the importance of sex education by issuing ministerial directives to national, state, and municipal authorities. Responsibility for developing the project was originally assigned to the Presidential Council for Youth, Women, and Family/*Consejería Presidencial para la Juventud, la Mujer y la Familia* (CPJMF), which was established in 1990 and was subsequently transferred to the Ministry of Education. UNFPA has provided support for this project, and the importance of sex education has clearly been heightened because it is now a requirement in the school curriculum for primary and secondary education.

Three NGOs were engaged to implement the project: PROFAMILIA, CRESALC,²⁰ and the Foundation for Development of Health Education in Colombia (FUDESCO). The role of PROFAMILIA has been discussed extensively elsewhere in this report. CRESALC has served as an important resource in the area of sex education for youth not only in

²⁰ Funded by Swedish International Development Authority.

Colombia, but also in other Latin American countries. The organization has advised the Ministry of Education in developing a policy on sex education and has provided technical assistance for introducing sex education into the curriculum, for training teachers, for preparing curricular materials, and for serving in an advocacy role before the Colombian Congress and with the media.

The project has had mixed results in the services area and has shown promising results in the education sector. PROFAMILIA developed and implemented a useful model of training and services through its adolescent centers. With few exceptions, CRESALC and FUDESCO had much more difficulty in getting public entities to integrate services for adolescents. And yet, the educational activities directed to health service personnel, parents, teachers, and youth leaders are considered to have been quite productive. The training within schools has focused on prevention of adolescent pregnancy and sexually transmitted diseases (STDs), on changing attitudes toward adolescent sexuality, on use of contraceptives, and on gender roles (Corona et al., 1996). Results of a 1996 Ministry of Education evaluation of the project in 185 schools showed that almost all of the schools visited had carried out planned educational activities and that three-quarters of the schools found positive changes in attitudes among students and teachers (Prada, 1997). As in the case of efforts in population education, the reach of the sex education program through the schools has been limited so far. Although some 55,000 educational institutions fall under the mandate of Law 115, only 2,500 of the 240,000 Colombian teachers have received training in sex education under the program (UNFPA, 1997; Corona et al., 1996). The question remains as to whether there are sufficient human and financial resources to carry out full-scale implementation on a national level.

Because of a recent reorganization at the Ministry of Education, the population education and sex education programs have been integrated. Since these two programs are very similar in many respects (except for the demographic and development content of the population education part), it makes good sense to combine the efforts. In general, there is more support and interest in the sex education program, no doubt in part because it is a requirement in the school curriculum. We hope this integration will improve the likelihood that the Ministry will fully support and implement a national plan for this important area of education.

4.4 Public and Private Sector Collaboration

During most of Colombia's 30 years of experience in family planning programs, relations between public and private programs have been good. In the first years, the MOH and ASCOFAME worked very closely, given (a) ASCOFAME's support of the MOH service infrastructure and its personnel and (b) the transfer of its programs to the MCH Division. The collaboration between MOH and PROFAMILIA has been good, on the whole, although it has not been entirely free of difficulties. Examples of this collaboration follow.

- The MOH always permitted PROFAMILIA to use its infrastructure for educational and informational campaigns and for expanding programs such as surgical sterilization.
- PROFAMILIA has participated in MOH's committees and assessment groups on family planning.
- PROFAMILIA has trained MOH personnel in multiple activities and in most of its clinics. PROFAMILIA personnel have participated in educational courses given to MOH personnel.
- The MOH has always supported PROFAMILIA's importation of contraceptive commodities and their tax-free status in Colombia.
- PROFAMILIA, SOMEFA, and the MOH have worked together to lend or donate commodities when there was a scarcity of contraceptives in one institution.
- PROFAMILIA has helped channel funds from CAs to the MOH.
- PROFAMILIA has participated, among other NGOs, on the Government's Council on Population (the advisory body that includes representatives from several important ministries).

Relations between the MOH and PROFAMILIA are at a high point now, in part because the MOH sets norms and standards and no longer implements programs. In the past, there have been confrontations between these two institutions. The most outstanding example occurred in 1984 when the Colombian Cardinal spoke out against the payments to physicians for female sterilization being performed by the MOH with help from PROFAMILIA. The then-Minister of Health let PROFAMILIA confront the Catholic Church's hierarchy alone in this bitter fight. Furthermore, in the middle of this controversy, the Minister issued a resolution on family planning in Colombia (*Resolución de Ministro de Salud 08514*, 1984). This resolution established the processes to carry out programs, but it limited the independence of PROFAMILIA and other NGOs to receive

international funds. Fortunately, the resolution was never put into practice, although it did leave profound grudges.

The communications media played a very supportive role in the course of this controversy with the Catholic Church. The media not only helped defend PROFAMILIA, but also came out clearly for the right of individuals to decide for themselves about the number and spacing of their children. Thus, the media were important allies contributing to the debate over family planning programs. After this, the Catholic Church never again attacked family planning, but rather concentrated its efforts on opposing abortion and sex education, struggles in which the Church has largely been successful.

5. THE ROLE OF EXTERNAL ASSISTANCE

The availability of external assistance for family planning and population programs in Colombia has been a very important factor in their success. Given the many players and the various types of assistance over a 30-year period, the following discussion is by necessity selective rather than comprehensive. We, the authors, hope that we have done justice to most of the external participants in the Colombia story.

The sources of support have been many:

- Private U.S. foundations (principally the Ford Foundation and the Rockefeller Foundation, the Milbank Memorial Fund in the early years, and most recently Bergstrom, Hewlett, and McArthur)
- Private U.S. institutions²¹ (the Population Council, Population Reference Bureau, and universities such as Chicago, Columbia, Cornell, Michigan, and Tulane)
- International private organizations (IPPF with headquarters in London and Marie Stopes)
- Bilateral government assistance (USAID, Canadian International Development Agency plus the International Development Research Centre, Swedish International Development Agency, Japan International Cooperation Agency (JICA), and German Association for Technical Cooperation (GTZ))
- Multilateral assistance (principally UNFPA, Pan-American Health Organization [PAHO], World Bank, UNICEF, ILO, UNESCO, and UNDP)

A number of other U.S. institutions, referred to as Cooperating Agencies, that have received substantial support from USAID for their work in Colombia are AVSC International, Development Associates, Family Planning International Assistance, The Futures Group, the IPPF/Western Hemisphere Region, Johns Hopkins University, Pathfinder International, the Population Council, and Macro International, Inc., and its predecessors (the Institute for Resource Development of Westinghouse and Westinghouse Health Systems).

The following discussion presents the role of USAID and of other donors more or less chronologically, followed by a more in-depth discussion of the contribution of CAs.

²¹ It is likely that much of this support was actually funded by private U.S. foundations or USAID.

5.1 USAID and Other Donors

Many sources have provided different types of assistance including financial, technical assistance and training, and commodities. In the mid-1960s, the Ford Foundation and the Rockefeller Foundation supported several seminal meetings and workshops in Colombia that were attended by health professionals, social scientists, teachers, and journalists. They also funded training and technical assistance. The Ford Foundation's support was particularly helpful in launching the work of ASCOFAME's Division of Population Studies. The Population Council was an early contributor to population research and training in Colombia, initially through the International Program of Postpartum Family Planning (Castadot et al., 1975). As mentioned in Section 2.3.2, a number of U.S. universities helped train a cadre of professionals, many of whom are still active in the population field.

USAID was the first bilateral donor in population. The first bilateral agreement with the GOC was signed in 1966 for US\$320,000. Through ASCOFAME, the agreement provided financial support for an in-service training program for public health officials on the impact of demographic factors for development and health, and for training on contraceptive methods. Two bilateral health sector loans to the Ministry of Health followed in the 1970s. The long- and short-term technical assistance to the MOH was provided through PAHO (Echeverry, 1991). Although the provision of family planning services was not an explicit component of the first loan, it was understood that a portion of the funds would support such services within the context of the MOH's maternal and child health program. Bilateral assistance from USAID was phased out in the mid-1970s when President López (1974–1978) stated that such assistance was no longer needed. However, increasing levels of support were being provided to the GOC from the primary multilateral source: the UNFPA. As bilateral assistance declined, USAID, through its CAs, increased technical and financial assistance to the Colombian private sector. (See Section 6.2.)

For the 30-year period from 1966 to 1996, USAID contributed between US\$45 million and US\$50 million (not including the value of contraceptive commodities) directly to Colombia's family planning and population programs. USAID bilateral assistance to the public sector amounted to US\$3.8 million during 1967–1977 (Bair, 1978). Assistance through USAID CAs to PROFAMILIA is estimated at about US\$41million, and an additional level of technical assistance was provided by the CAs to public sector programs (PROFAMILIA, 1996). Although estimates of the value of donated commodities are lacking for the early years, from 1986 to 1996 USAID provided contraceptive commodities (condoms, pills, IUDs, and NORPLANT) primarily to PROFAMILIA valued at about US\$6 million (John Snow Inc. [JSI], NEWVERN Information System, 1997). During many of the 30 years of assistance, USAID contributed to the programs of the UNFPA and the IPPF, thus indirectly supporting population assistance to Colombia. Finally, the preceding estimate of the assistance provided by the CAs is conservative because it does not cover the indirect costs of their efforts. In sum, USAID and the CAs

have been among the most important sources of technical and financial assistance to Colombian programs.

In 1967, IPPF began providing assistance to PROFAMILIA for its growth and development and has been a continuing source of financial support for PROFAMILIA's administrative costs. IPPF has also been a source of funds to purchase contraceptive commodities in the local Colombian pharmaceutical market, as well as a source of in-kind commodity donations. The level of annual financial support has averaged US\$2 million, with perhaps 60 percent of this amount providing core support for personnel and administrative costs.²² The total amount of funds including commodity support from 1969 to 1997 is probably about US\$50 million.²³ Through international meetings and publications, IPPF and IPPF/WHO have served as important fora for PROFAMILIA to share its experiences and exchange information with IPPF's affiliates worldwide, especially with those in Latin America and the Caribbean.

UNFPA assistance to Colombia, which began in 1972, has supported maternal and child health and family planning activities primarily with the MOH. To a lesser extent, assistance was provided to PROFAMILIA (about \$620,000 from 1979 to 1995) (UNFPA, 1992). Funds were provided through PAHO until 1994 when UNFPA modified its assistance programs in Colombia and began to administer funds directly. UNFPA's support was used in various ways, but principally in (a) funding both national and international technical assistance, (b) purchasing supplies including contraceptives (mainly IUDs and pills), and (c) training and supervising personnel. Other UNFPA support has been provided for data collection and analysis, population policy development, integration of demographic variables into planning, population and sex information and education, and adolescent programs through a number of GOC offices and ministries including the Department of National Planning; the Ministry of Education; the National Administrative Department for Statistics (DANE); and the National Council for Youth, Women, and the Family. The estimated level of assistance from UNFPA to Colombia from 1972 through 1997 is US\$20 million (UNFPA, 1997).

In addition to USAID, JICA has provided Japanese bilateral assistance to the MOH. This assistance supported the Maternal, Child, and Family Planning programs for marginal zones in Bogotá and in the Department of Antioquia in the mid-1980s. The assistance funded the purchase of equipment, as well as the training in Japan of MOH officials in the management and administration of family planning programs. This program was not renewed because of security problems in Colombia. Japanese funding to PROFAMILIA through the private agency JOICFP supported an integrated family planning and parasite control project. Germany's assistance agency GTZ and Canada's IDRC also supported population activities in Colombia.

²² This average is based on six years of funding: 1973, 1980, 1986, 1990, 1996, and an annualized estimate for 1997. See Table A6 in the Statistical Appendix for details.

²³ There is some double counting between this estimate and the USAID funds discussed in the preceding paragraph because some of the USAID funds were provided through IPPF.

In many countries with strong family planning programs, there is an effective mechanism such as a government-sanctioned coordinating body to facilitate donor assistance, but not in Colombia. Although significant bilateral, multilateral, and NGO support has been provided in family planning and population to both the public and private sectors, most activities have been carried out with little coordination. UNFPA attributes this to the lack of a full-fledged national population program and to the relatively low profile of the Population Division in the Department of National Planning, a unit that could have played the role of coordinator if the GOC empowered it to do so (UNFPA, 1992).

5.2 Cooperating Agencies in Population

Over the years, numerous CAs have been important sources of technical assistance and funds, primarily to PROFAMILIA and to a lesser, but still significant, extent to the MOH. The contribution of the CAs has been substantial in many ways, although it is impossible to assess the contribution in quantitative terms. An in-country presence is one aspect of CA assistance that is considered to have been very important. Organizations such as the Population Council, Pathfinder International, and AVSC International maintained a local presence, frequently with Colombian experts as staff members.²⁴ The individuals representing these organizations not only were technically very qualified, but also were culturally attuned.

Another aspect of the CA contribution is the broad range of technical areas available through the CAs' projects. This assistance was drawn on to bring particular expertise needed at any given time in Colombia. Such expertise covered data collection; research; evaluation; training; service delivery; commodities; and information, education, and communication (IEC). CAs' technical assistance projects that were active (and a few still are with non-USAID funding) in Colombia run the gamut, as evidenced by these examples:

- Data collection and analysis through the Demographic and Health Surveys Project (DHS) and its predecessor projects
- Operations research through the Operations Research in Family Planning and Maternal-Child Health for Latin American and the Caribbean (INOPAL) and its predecessor projects
- Training for nurses and paramedical personnel through Development Associates and Pathfinder International projects
- Training of pharmacists and pharmacy staff members by Pathfinder International

²⁴ In the early years of the program, the Ford Foundation also had a local representative.

- Training for medical physicians in various sterilization techniques, counseling, and NORPLANT through AVSC International and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)
- Design of mass media campaigns to promote family planning through Johns Hopkins University Population Communication Services
- Service delivery through clinics and community-based distributors funded by Pathfinder International
- Social marketing of contraceptives through the International Contraceptive Social Marketing Project (ICSM) and its successor projects of The Futures Group
- Financial sustainability through the Transition and Matching Grants Projects of the IPPF/WHO

Not only was the range of expertise provided by these projects very broad, but also the mode of assistance of these “intermediary” organizations was extremely flexible. Subprojects were developed and funded quite rapidly. This flexibility especially characterized the CAs’ relationship with PROFAMILIA. Having private institutions (the CAs on the one hand and PROFAMILIA on the other) at the heart of the assistance relationship facilitated the development and innovation of PROFAMILIA and, thereby, the rapid expansion of the program’s service delivery coverage.

The relationship between CAs and PROFAMILIA is viewed by many individuals associated with the program over the years as having been mutually beneficial. For example, the initiation of PROFAMILIA’s rural CBD program was also the beginning of applied, or “operations,” research in Colombia. Not only did the family planning and the research communities in Colombia benefit, but also a good number of researchers from outside Colombia learned the tools of their trade through operations research at PROFAMILIA. Thus, the international research community and population programs in other countries benefited.

With funds from USAID, several CAs supported special activities of the MOH’s MCH Division program until 1986. For example, JHPIEGO supported the purchase of laparoscopes, equipment maintenance, and training of personnel in the use of such equipment both for diagnosis and for female sterilization. The Population Council collaborated in various operations research studies including one to determine if rural health promoters could effectively distribute contraceptives, particularly pills.

Pathfinder International probably collaborated the most with the MOH. Its assistance continued from 1975 until its Regional Office in Bogotá was closed in 1990. Pathfinder International donated contraceptives (particularly condoms and IUDs), and its funds were used to train personnel, to support demonstration programs such as training nurses to

insert IUDs, and to expand female sterilization services (minilaparotomy through training and the provision of minilap kits) in the MOH's second- and third-level hospitals.

Two other CAs collaborated with the MOH: (a) Family Health International supported a study to evaluate pill compliance by rural women who had been instructed by rural health promoters, and (b) Development Associates funded censuses of women of reproductive age, a compilation carried out by health promoters in rural communities.

AVSC International also supported public sector programs. Beginning in 1983, and complemented by Pathfinder International, AVSC International assisted the MOH's sterilization services in public hospitals. Subsequently, AVSC helped fund (a) the decentralization of the family planning program, (b) the establishment of regional centers for training in the use and follow-up of contraceptive methods, and (c) programs at public hospitals. In general, AVSC International's support facilitated decentralization by helping to strengthen regional institutions to administer their reproductive health programs.

5.2.1 International Planned Parenthood Federation (IPPF) in Colombia

The history of IPPF's role in Colombia predates the establishment of its affiliate, PROFAMILIA. The first recorded assistance was given in 1965 for training through ASCOFAME's Division of Population Studies. IPPF was part of a consortium of funders for such training. While IPPF has maintained its headquarters in London since its founding in 1952, the Western Hemisphere Region (WHR) office was established in New York in 1965 to facilitate assistance to countries in Latin America and the Caribbean. IPPF/WHR first received assistance from USAID in 1965, in effect becoming one of USAID's first Cooperating Agencies.

PROFAMILIA has been an affiliate of IPPF since 1967 and was a typical fledgling volunteer organization with few resources in those early years. IPPF provided core support for administrative costs, enabling PROFAMILIA to grow and flourish. Special recognition is due to IPPF because its core support, which was used to strengthen planning, accounting, and other basic systems of PROFAMILIA, has been invaluable. Further, this core support enabled other CAs to make their "investments" solely for project activities. With IPPF and other donor assistance, by 1969, PROFAMILIA had become the largest private affiliate in the WHR (Echeverry, 1991).

IPPF's principal contributions to PROFAMILIA have been funds and contraceptive commodities totaling about US\$50 million. Core support from IPPF/London to PROFAMILIA has been channeled through IPPF/WHR for many years. In addition, USAID has also provided funds and assistance to PROFAMILIA through two successive

regional projects with WHR—the Matching Grant (1985–1991) and the Transition Project²⁵ (1992–1997)—to expand and improve family planning services in the region.

Under the Matching Grant, PROFAMILIA developed and pursued a strategy to expand and diversify its services, to increase income from the sales of these services, and to use this income to fund family planning services. PROFAMILIA also carried out research on client satisfaction and on the effects of the diversification strategy. IPPF/WHR provided financial support and technical assistance for the research and also supported some “South-to-South” assistance by PROFAMILIA, especially in the area of cost accounting for other FPAs.

Through the Transition Project, IPPF continued to support PROFAMILIA’s diversification and efforts to further define sustainability and measure success in achieving it. Funds were provided to upgrade a number of clinic facilities and to buy new equipment. Technical and financial assistance was given to improve PROFAMILIA’s management and financial information systems. The IPPF/WHR staff assisted PROFAMILIA in developing proposals to various funding sources including the McArthur and Hewlett Foundations, as well as to UNFPA and CIDA.

PROFAMILIA and IPPF/WHR evaluation staffs jointly developed a methodology for assessing client satisfaction. The method has three parts: (a) client satisfaction surveys, (b) client flow analysis, and (c) focus groups. PROFAMILIA has set a very demanding threshold for client satisfaction. If more than 5 percent of clients are unhappy with services, the organization or clinic is deemed to have a problem. Results of this evaluation are presented to clinic directors who, in turn, are challenged to improve their services.

An endowment fund was the final, critical component of USAID and IPPF/WHR’s assistance to PROFAMILIA. After 18 months of planning, the three organizations succeeded in setting up this fund. IPPF/WHR staff members served as the secretariat for the endowment fund under the Transition Project. USAID invested US\$6 million, which has since appreciated in value to US\$9.2 million. This fund is a worthwhile precedent to study for future application. (See Section 3.2.5.)

The total amount of funding provided by IPPF/WHR from 1986 to 1996 was US\$19.6 million, with another US\$6 million placed in the endowment fund.

IPPF/WHR staff members believe that PROFAMILIA has benefited from its own endeavors with other affiliates in the region as much as—if not more than—it has from IPPF/WHR’s assistance. PROFAMILIA’s staff members have served frequently as advisors for IPPF/WHR on key issues such as diversifying services and maintaining sustainability. In making the strongest possible compliment, a former USAID project

²⁵ The full name of the Transition Project is Expansion and Improvement of Family Planning Services in Latin America and the Caribbean: The Transition to Sustainable Programs.

manager for the Transition Project stated, “PROFAMILIA is one of USAID’s best investments.”

The next two sections list two other examples of CA assistance in Colombia: AVSC and Pathfinder International, which have been active there since the early 1970s.²⁶ These provide additional insight into the varied and important contributions of CAs to family planning and population activities in Colombia.

5.2.2 AVSC in Colombia

AVSC, a private, nonprofit U.S. organization, has worked in Colombia since 1971. It has assisted PROFAMILIA, the MOH at both regional and municipal levels, and the private schools of medicine. AVSC has provided technical and financial support for clinical services and training in male and female sterilization, in IUD insertion, and in the use of NORPLANT. AVSC has maintained a regional office in Bogotá since 1983, first for South America and, beginning in 1985, for the entire Latin American and Caribbean region.

Through its technical assistance, AVSC emphasized a high standard of training in surgical techniques, as well as careful counseling of users to ensure voluntary and informed consent. AVSC has carried out training of Colombian medical and paramedical staff and has also provided support for surgical equipment and careful evaluation of voluntary surgical contraception (VSC) programs.

As an example of program evaluation, in 1985 PROFAMILIA and AVSC collaborated on a follow-up study of acceptors of both laparoscopy and minilaparotomy sterilization procedures. (Previous evaluations had been carried out by PROFAMILIA in 1976–1977 and 1978–1983.) The study looked at client satisfaction, client characteristics, client knowledge about the chosen method, costs, and cost-effectiveness. Results showed high levels of overall satisfaction with PROFAMILIA’s sterilization program; further, findings demonstrated that the program was the least costly service program per CYP. Other results led to improvements in the program’s implementation (Williams et al., 1990).

Over the years, AVSC has worked with PROFAMILIA to improve its services for men. PROFAMILIA opened its first male clinic in 1985 and has more than 10 years of experience in serving male clients not only with vasectomy, but also with a wide range of methods of reproductive health services and specialized counseling. Among the findings of a recent case study by AVSC on PROFAMILIA’s clinics for men is that separate services for men are useful but not essential and that good counseling is very important (AVSC and PROFAMILIA, 1997).

²⁶ These two organizations were selected because they provided assistance to both private and public institutions and also because the authors had sufficient information on their activities, thanks to the material provided by Colombian representatives of both AVSC and Pathfinder International who were in Colombia at the time of the field work for this report. Their selection does not diminish the fine work of other CAs in Colombia.

From 1993 to 1996, AVSC worked to revitalize VSC programs in local and regional hospitals and in MOH facilities. The training strategy was directed partly to strengthening several national training centers such as the *Instituto Materno-Infantil* of the *Universidad Nacional de Colombia*, which is an important maternity hospital because of its specialization in obstetrics and gynecology (OB-GYN), its research, and its training of many health professionals in OB-GYN. The training at MOH hospitals focused on medical teams in an attempt to build both team spirit and individual responsibility on behalf of all team members. This approach was found to be as important as training in the particular methods and techniques (AVSC, 1996). (See also Section 7.2.)

Over its entire period of assistance to Colombia, AVSC has contributed about US\$7.5 million: US\$4.3 million was in grants to PROFAMILIA, roughly US\$1.7 million was for the MOH and other service programs, and the remaining US\$1.5 million was the cost of technical assistance from AVSC.

5.2.3 Pathfinder International in Colombia

Pathfinder International, one of the first U.S. nonprofit organizations to promote family planning programs in developing countries, opened its office in Colombia in 1973. For 17 years, it played an important role in providing technical and financial support for developing family planning in Colombia. Among the Colombian institutions that benefited from Pathfinder's assistance is an impressive array of private and public entities. Private groups include ACEP, ASCOFAME, CCRP, PROFAMILIA, SENA, and SOMEFA. Universities such as *Universidades de Caldas, de Javeriana, and del Valle* also received assistance. Public entities that received Pathfinder support included the MOH's MCH Division; the armed forces; the Secretaría de Salud de Bogotá; and the Servicios Seccionales de Salud de Antioquía Atlántico, Caldas, and El Valle (Pathfinder Fund, 1990; Rizo, 1997).

The types of assistance funded by Pathfinder International are even more numerous than the cooperating institutions. This diversity speaks to the great flexibility that the organization maintained, allowing it to address various needs and to provide support expeditiously. Pathfinder International's support was directed to three priority areas: (a) institutionalizing family planning services within the public sector, (b) addressing the needs of the adolescent population, and (c) providing opportunities for professional training and exchanges. The assistance served to motivate and train many important decision makers in critical areas such as service delivery, qualitative evaluation, adolescent services, and quality of care.

By far, the largest amount of Pathfinder International's resources and technical support went to PROFAMILIA. The assistance helped increase access to family planning services within the more isolated populations, both through the rural CBD program and through clinics in smaller towns such as Florencia, Tumaco, Quibdo, and Riohacha. Pathfinder International supported training, equipment, and services for male and female VSC at PROFAMILIA's clinics and in its mobile programs.

In its support of the public sector, Pathfinder International assisted in institutionalizing family planning services in the structure of the MOH and in providing family planning services at the departmental level in various locations. Pathfinder supported training of medical, nursing, and administrative staff to deliver contraception. Further, its technical assistance and training laid the groundwork for the MOH's development of service delivery norms in family planning and for the general acceptance of family planning as a right of individuals of reproductive age. That right is now firmly established in the Colombian health system.

Pathfinder International supported a systematic effort to ensure that sexually active adolescents be considered as a priority group for family planning information and services. Among the activities supported was the Adolescent Hospital-Based Service Delivery Project at the *Hospital Infantil Universitario Lorencita Villegas de Santos* in Bogotá. Through this project, a core group of university professors, residents, and medical students were committed to addressing the problem of adolescent pregnancy, which accounted for one-quarter of all Colombian obstetrical patients. A number of these trained professionals subsequently served as advisors to the MOH in developing norms for adolescent health care, helped train service providers in various departments, and assisted in the initiation of special activities such as Integrated Health Services for Adolescents. Other adolescent projects included (a) the Adolescent Health Care Program in Manizales as part of the Health Service of Caldas (subsequently funded by the Kellogg Foundation, by PAHO, and later by the Department of Caldas), and (b) the incorporation of human sexuality into the curriculum of the School of Nursing of the *Universidad del Valle*, an initiative that is today fully institutionalized and locally supported.

Pathfinder International supported many training opportunities through courses or regional and international meetings, such as the World Congress of Obstetrics and Gynecology. In addition, this organization placed great emphasis on bringing professionals from other countries in the Latin American and Caribbean (LAC) region and from a number of African countries to Colombia to observe firsthand the work of institutions such as PROFAMILIA, ACEP, CCRP, *Universidad de los Andes*, and *Universidad del Valle*. This observational travel helped to inspire the testing of various Colombian strategies and activities in other countries, including (a) the urban and rural CBD programs of PROFAMILIA, (b) the training of nonprofessional groups in responsible parenthood by ACEP, (c) raising awareness among parliamentarians as to the links between population and development, (d) training of pharmacists and pharmacy staff in client information on family planning, (e) training of directors and administrators of family planning programs in qualitative techniques for program evaluation, and (f) adolescent service programs.

Pathfinder International also provided support to SOMEFA to train private physicians in family planning and in specific contraceptive methods such as minilap and NORPLANT. Contraceptive and other commodities (pelvic models, IUD insertion kits, and vasectomy kits) were provided to PROFAMILIA, the MOH, and others. Various publications (e.g., Dr. Benjamin Viel's book on *Population Growth in Europe and the Americas*) and

training films (such as a video on qualitative evaluation) were widely distributed in Colombia and elsewhere in the region thanks to Pathfinder International's support.

According to Pathfinder International, it provided more than US\$5 million in technical assistance and support to Colombia, not including contraceptive commodity support. Most of this assistance (US\$4.3 million, or 84 percent) was given to PROFAMILIA, the MOH was the second largest recipient, and the remainder was distributed among many other institutional and individual recipients.

5.3 Conclusion

Colombia was not unique in the wide range of sources of support and the types of assistance that it received. The amount of the assistance through the NGOs including the USAID CAs is considered by some to have been very important. For example, having ample financial resources no doubt facilitated the rapid expansion of key program areas such as CBD at PROFAMILIA. The level of support ranged from relatively small grants of US\$1,000 to substantial grants in excess of US\$400,000. The total level of support from NGOs is estimated at about US\$87 million (see Table 7), or about 70 percent of all external assistance. NGOs were the most important channel of assistance to Colombia. The authors' consensus is that these funds were well invested in Colombia's family planning and population programs and that the funds were managed carefully and properly. The investment produced laudable results, as discussed in Section 6.

Table 7

**Summary of External Population and Family Planning Assistance
to Colombia by Source, 1967-1997
(U.S. \$ in thousands)**

Year	Bilateral	Multilateral	NGOs	Total
1967	50	0	0	50
1968	116	0	0	116
1969	97	182	543	822
1970	524	357	771	1,652
1971	438	695	1,744	2,877
1972	687	855	1,959	3,501
1973	600	1,015	2,027	3,642
1974	470	1,264	2,748	4,482
1975	436	1,400	3,385	5,221
1976	240	1,512	2,817	4,569
Subtotal	3,658	7,280	15,994	26,932
1977	240	1,660	3,553	5,453
1978	0	521	3,040	3,561
1979	0	733	3,040	3,773
1980	0	613	2,619	3,232
1981	0	613	3,040	3,653
1982	0	585	5,269	5,854
1983	0	1,266	2,569	3,835
1984	92	1,153	3,319	4,564
1985	131	1,223	3,013	4,367
1986	500	357	2,714	3,571
Subtotal	963	8,724	32,176	41,863
1987	840	210	2,452	3,502
1988	1,537	385	5,765	7,687
1989	973	1,043	4,867	6,953
1990	1,455	443	4,428	6,326
1991	103	1,386	1,975	3,464
1992	933	593	2,713	4,239
1993	828	736	3,036	4,600
1994	649	603	3,385	4,637
1995	2,139	713	6,061	8,913
1996	na	na	2,652	2,652
1997	na	na	1,357	1,357
Subtotal	9,457	6,112	38,691	54,260
Total	14,078	22,116	86,861	123,055

Sources: Blair, 1978 for 1967-1997; UNFPA, 1992 for 1982-1985; UNFPA, 1977 for 1986-1995, PROFAMILIA, Table on Donaciones AID a traves de Otras Agencias, 1972-1996, March 12, 1996 for estimates of funds to PROFAMILIA for 1978-1981; and PROFAMILIA, Table on Donaciones del Exterior, IPPF, November 10, 1997 for IPPF donations for 1980, 1996, and 1997.

1. USAID assistance through PAHO shifted to UNFPA beginning in 1974
2. Assistance from 1967-1977 includes only funds that went directly to Colombia and does not include the cost of technical assistance provided by the NGOs. The value of donated commodities is included in these estimates.
3. Assistance from 1986-1995 is counted in terms of actual expenditures. The value of donated commodities is included in these estimates.
4. The definition of population assistance by UNFPA changed in 1995 so that funds for a broader range of areas (STDs, postabortion care, and other costed elements of reproductive health) were included in 1995. For the earlier years, support for population included expenditures for family planning, census activities, policy, and demographics analysis.
5. Information for the following years is very limited: 1978-1981. The following assumptions have been made for these years:
 - The amount of bilateral assistance is zero (President Lopez [1974-1976] ended U.S. bilateral assistance during his term.)
 - The amount of \$613,000 for multilateral assistance in 1980 and 1981 is based on an average for 1978, 1979, and 1981.
 - The amount of \$3,040,000 for assistance from NGOs for 1978, 1979, and 1981 is based on an average for 1973--1987 excluding the three years for which there is no information.
6. The estimates for assistance from NGOs in 1996 and 1997 includes only those funds provided by IPPF. The 1997 estimate is based on funds provided from January to August 1997.

6. THE IMPACT OF FAMILY PLANNING IN COLOMBIA

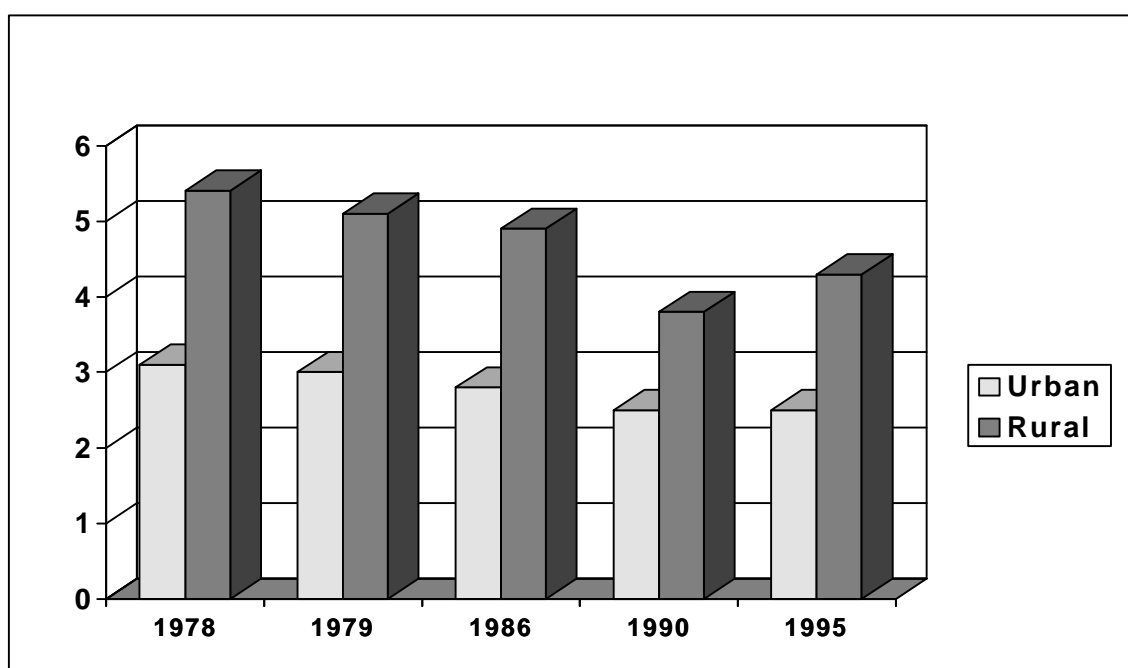
Over the past 30 years, Colombia has experienced an impressive reduction in fertility and a substantial increase in contraceptive use. The total population of Colombia was 37.8 million in 1997. Had the high population growth rates of the 1960s persisted, the population would have totaled 50 million, or 32 percent larger than the current population.

6.1 Fertility and Contraceptive Use in Colombia

The historic level of high fertility in Colombia began to change in the 1960s just as family planning programs were being initiated. As shown in Table 9, fertility (as measured by the total fertility rate, or TFR) dropped from a high of 6.0 in 1969 to 3.0 in 1995. The decline in fertility occurred in both urban and rural settings. In urban areas, the TFR declined from 3.1 in 1978 to 2.5 in 1995, while in rural areas it dropped by more than one child, from 5.4 to 4.3. (See Chart 2.)

Chart 2

**Trends in Total Fertility Rate by Residence in Colombia,
Selected Years, 1978-1995**



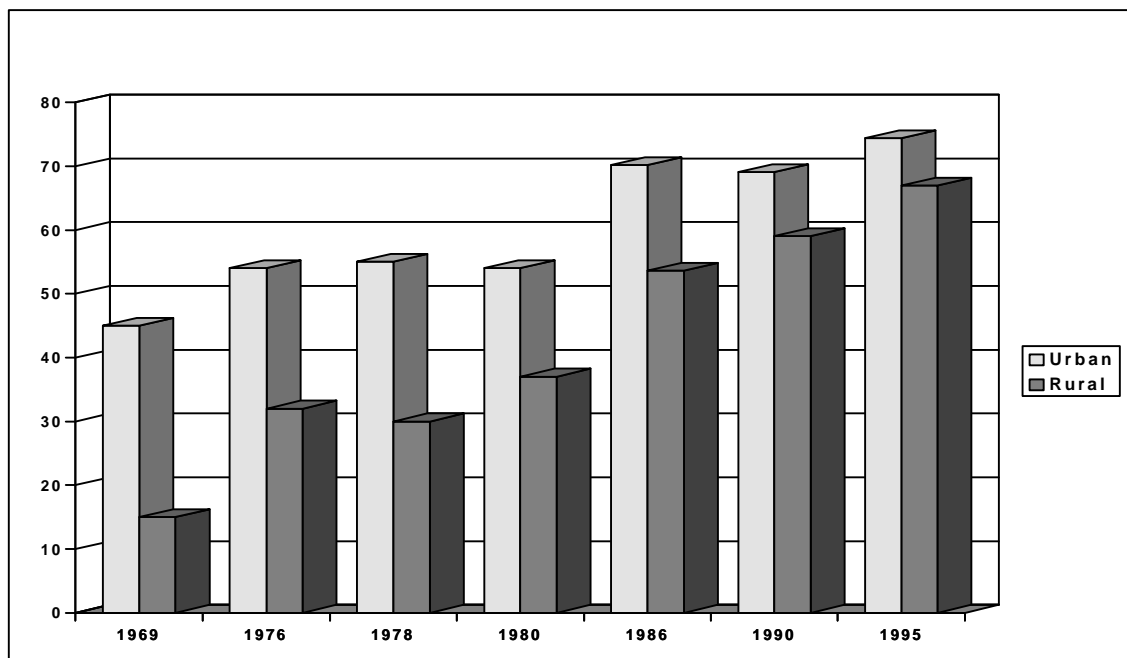
The first study of contraceptive use conducted in 1963–1964 found that 27 percent of women in union in Bogotá were using a method of contraception, mostly traditional methods such as rhythm or withdrawal (Miro, 1966). In the first national fertility survey of 1969, 35 percent of women in union of reproductive age were using contraception and 18 percent were using a modern method (i.e., pill, IUD, or sterilization) (see Table 3). The

increase in use of modern methods was impressive, given that only a few years had passed since modern methods had become available in drugstores around the country and since the first family planning programs had been started. The 1969 survey results were prescient of the course of contraceptive use in Colombia. From that time on, the use of contraceptive methods and especially modern methods continued to rise, reaching 72.2 percent in 1995.

Contraceptive use by residence reveals some interesting trends as seen in Chart 3. Using the 1963–1964 survey in Bogotá as a proxy for all urban areas, we find a dramatic increase—a doubling—of contraceptive use among women in urban areas from 27 percent to 54 percent during the first decade or so of family planning programs. Between 1975 and the early 1980s, contraceptive use reached a plateau. Sometime after 1980, contraceptive use again jumped and increased to more than 74 percent by 1995.

Chart 3

**Trends in the Use of Contraception by Residence in Colombia,
Selected Years, 1969-1995**



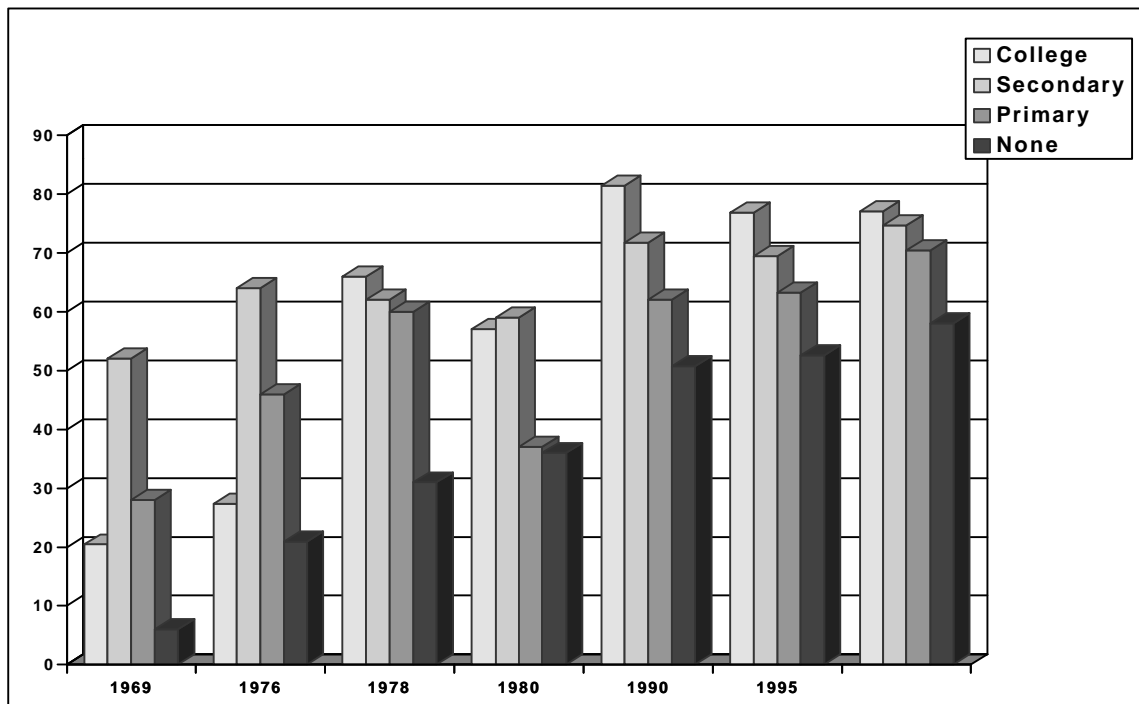
Source: Several Surveys of Demography, Fertility, and Prevalence

Contraceptive use in rural areas showed roughly similar trends, although at lower levels. Use more than doubled among rural women, from 15 percent to 32 percent between 1969 and 1976, but remained relatively steady until the early 1980s. Between 1980 and 1995, use among rural women increased sharply by 30 percentage points reaching 67 percent, a strikingly high level of use for rural areas. Contraceptive use by education also shows that women with primary or more education achieved very high levels of use (70 percent or more) by 1995 (see Chart 4). Over the years, use among the least-educated group of

women shows steady increases, even though the levels of use are consistently lower than those for the more educated women. By 1995, a majority of women with no education were using contraception.

Chart 4

**Trends in the Use of Contraception by Education of Colombian Women,
Selected Years, 1969-1995**



Source: Several Surveys of Demography, Fertility, and Prevalence

Table 8 shows the sources of modern methods of contraception from 1978 (see also Chart 5). In that year, drugstores and PROFAMILIA each supplied about one-third of all methods, although PROFAMILIA was a major supplier of methods to drugstores; hence its role as a supplier was probably much greater. The public sector provided services for more than one-quarter of the population. Over time, drugstores have been a consistent supplier of modern methods (pills and condoms). PROFAMILIA has also been a very important provider, reaching a high of nearly 40 percent of the population of users in the mid-1980s. The public sector has been a significant provider of services, ranging from a high of 34 percent in 1980 to a low of 15 percent in 1986. These fluctuations suggest some misreporting, as discussed in Section 4.2. The overall trends show that the public sector has usually served about 25 percent of the population of users.

Table 8**Trends in Contraceptive Use by Source of Modern Methods
in Colombia, Selected Years, 1978–1995**

Source	1978	1980	1986	1990	1995
Public Sector ^a	27.4	34.3	15.3	22.7	27.1
PROFAMILIA	32.5	22.0	38.7	32.1	28.8
Drugstores	34.5	35.6	33.6	28.6	33.1
Other Private	3.4	6.7	11.8	13.6	10.2
Other	2.4	1.4	0.6	1.5	0.3
Total ^b	100.0	100.0	100.0	100.0	100.0

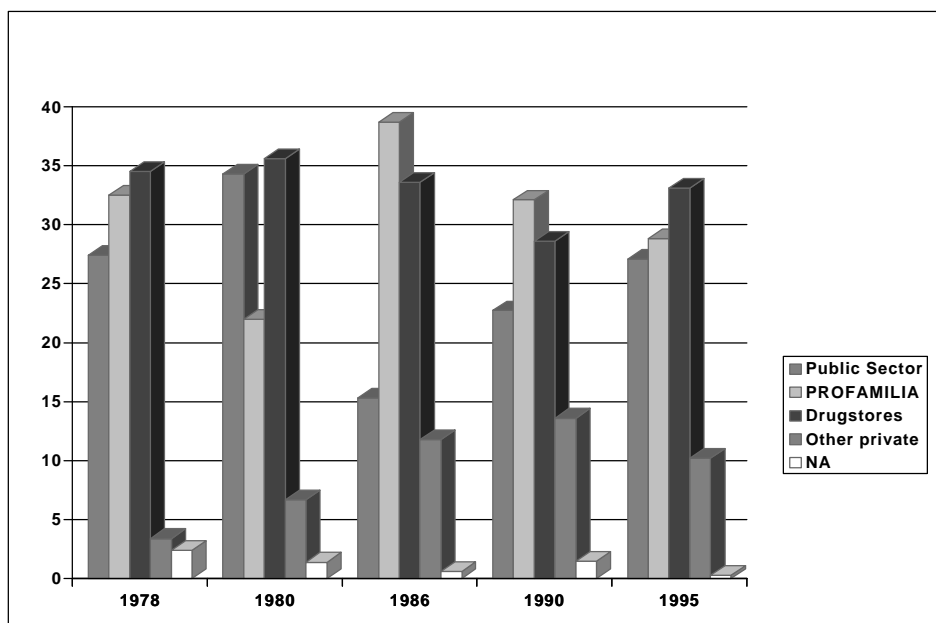
Sources: CCRP et al., 1979, 1981, 1986; and PROFAMILIA et al., 1991 and 1995.

^a Public sector includes services provided by the MOH through hospitals, clinics, and health posts as well as by Social Security. The MOH's share of service provision is as follows: 1978—22.9%, 1980—29.7%, 1990—19.4%, and 1995—23.0%.

^b The actual percentages do not always equal 100 because of rounding.

Chart 5

**Trends in Total Population Use by Source of Modern Methods
in Colombia, Selected Years, 1978-1995**



Source: Several Surveys of Demography, Fertility, and Prevalence

By 1995, drugstores had become the major supplier of modern contraception (temporary methods such as pills, injectables, vaginal methods, and condoms). The share of users of PROFAMILIA had declined somewhat and was only slightly higher than the public sector's share (about 29 percent, compared to 27 percent). Although not shown in the chart, PROFAMILIA was the major source of sterilization and implants and was an important source of IUDs. The public sector was the predominant supplier of IUDs and was a significant supplier of female sterilization. The high level of national coverage achieved by PROFAMILIA is unique among private, nonprofit family planning associations and sets PROFAMILIA apart from all other FPAs.

The trend in the relationship between the TFR and contraceptive prevalence is inverse. (see Table 9) As the use of contraception has gone up, the level of fertility has declined. One study conducted in the mid-1980s found that most Colombian women used contraception so they could have small families. Urban women generally used contraception to space births, while rural women used it to limit the number of births once they had reached their desired family (Florez et al., 1990). The authors concluded that the rapid increase in the availability of family planning services led to an increase in use of those services and to a reduction in fertility in the entire country.

Table 9

**Trends in Total Fertility Rate and Contraceptive Prevalence Rate
in Colombia, Selected Years, 1969-1995**

	1969	1976	1978	1980	1986	1990	1995
TFR	6.0	4.2	3.8	3.6	3.3	2.9	3.0
CPR	35.4	50.9	52.0	55.0	64.8	66.1	72.2

Source: Elkins, 1973; CCRP et al., 1979, 1980, 1982, and 1987; and PROFAMILIA, 1991 and 1995.

Although family planning programs and the increased use of contraception are considered the most important causes of the decline in fertility, other factors are also important: (a) the democratic character of Colombia that has ensured political stability and facilitated the adoption of family planning by individuals; (b) the freedom of speech and ample use of the media on themes such as responsible parenthood, contraception, sexuality, and abortion; (c) the high incidence of abortion that contributed to the fertility decline; (d) the increase in the educational levels of women (see Table 2; and Bayona, 1982); and (e) the combined processes of modernization and urbanization in Colombia over the past five decades.

6.2 Family Planning Programs in Other Countries

The family planning program in Colombia, especially the role of PROFAMILIA, is known worldwide. Since its establishment in 1965, PROFAMILIA has served as a demonstration center, a proponent of new ideas and strategies, a training center for health personnel of all levels, and a benchmark against which many programs have measured their results. Numerous examples illustrate how PROFAMILIA has served as a resource for programs in other countries:

- The Male Clinic in Bogotá was chosen as the site to introduce the no-scalpel vasectomy technique in Latin America. Doctors from Brazil, Guatemala, Mexico, and the United States were trained in this technique at the clinic.
- When a new Executive Director is appointed at an IPPF-affiliated association in another Latin American country, the initial preparation generally includes visiting PROFAMILIA. Recent examples have been visitors from Nicaragua, Panama, Paraguay, Peru, and Venezuela.
- PROFAMILIA has hosted various regional workshops for FPAs in Latin America on topics such as management information systems, evaluation, social marketing, and logistics. Furthermore, delegations with high-ranking officials from public and private programs in other parts of the world have visited PROFAMILIA to find out how the institution's programs are organized.

IPPF and CAs such as AVSC and Pathfinder International, frequently hire PROFAMILIA's personnel to carry out consultations in other countries. PROFAMILIA is also a resource for programs on other continents, especially Asia and Africa. Finally, PROFAMILIA was selected by UNFPA to be part of the South-to-South initiative that seeks to promote technical assistance among developing countries.

7. THE FUTURE

USAID assistance to Colombia has historically been an important part of the country's external assistance in population. The end of this support represents a significant loss in resources and has created uncertainty about the future of the family planning program. Fortunately, the reduction in external funding for family planning services is being replaced in part with internal resources generated under the reform in social security under Law 100 and in part through good management of existing resources. Colombia's experience will be valuable for other countries that face a similar reduction in external funds in the future. Thanks to the social security reform, Colombia will continue to be a leader in family planning and will provide a positive example for other countries. The role PROFAMILIA will play in family planning and in general health services in years to come remains to be seen, although the signs are promising.

This section presents a brief summary of the Colombian health reform and its implications for family planning. It also discusses a number of the continuing needs in the health area, especially for family planning and reproductive health. Despite the impressive achievements of the past 30 or more years, there will be continuing needs and challenges for services in family planning and reproductive health. Every year, new cohorts of Colombian youth will enter their reproductive years. These people will be deciding how many children they want and what spacing they want between births. They will want safe and effective methods of contraception to help them fulfill their desires and plans. Furthermore, there are still unmet needs for family planning among the adult population as is evident from recent survey data and from the continuing problem of unwanted pregnancies and the associated use of abortion.

7.1 Health Reform in Colombia

Colombia started on the road toward health decentralization in 1975 when the National Health System was created and when important delegations in health authority were made to the departments. The MOH was set up to direct the system and had ample power over financing and program execution. Regional authorities were entrusted with managing human resources and implementing programs. Through Law 10 of 1991, the MOH was converted into a normative entity. All authority for health services was passed to municipal mayors, leaving department-level governments with few duties. Municipal mayors are thus responsible for the health within their municipality, which includes designing plans and programs for health services and administering the funds to meet the health needs of people living in the municipality.

As mentioned earlier, the new 1991 Constitution gave Colombians the fundamental right to decide the number and spacing of births, and it became the state's obligation to facilitate the means by which citizens could achieve their objectives. In fulfillment of the constitutional mandate, a comprehensive reform in health and social security was

approved in 1993 as Law 100. This law reforms three fundamental aspects of social security: (a) retirement pensions, (b) work related accidents, and (c) health. In the health area, the reform establishes a general social security for the entire population with a unique obligatory health plan. A new feature allows institutions in the private sector to accept members and to offer services equal to those of the social security program, which has maintained a monopoly for more than 50 years.

Law 100 establishes various types of health care plans that define the health services to which Colombians are entitled. What is important about this legislation is that, for the first time, the GOC explicitly refers to family planning and expressly provides resources for family planning services. The obligation to offer information on sex education, reproductive health, and family planning is clearly established through three programs: the Basic Care Plan, the Obligatory Health Plan, and the Prevention and Promotion Program. In addition, medical care and contraceptive services are required for anyone who wants to use family planning. All birth control methods are recognized including female sterilization and vasectomy.

In the course of implementing the law, the providers of family planning services in Colombia are changing. Institutions that have traditionally played a part in this area have much to win and much to lose. They must redefine their roles among institutions that supply more general health services. Because of its size and importance, PROFAMILIA will obviously experience the greatest changes. At the same time, the Social Security Institute, which has provided general health services to a large affiliated population (12–13 million Colombians), has previously not been very interested in providing contraceptive services. With the new law, ISS will need to incorporate such services to meet the demand of its affiliates.

Given that Law 100 and the related regulatory guidelines set payments for family planning services, a great number of institutions that had never thought of offering such services are now including them in their portfolios. As a result, PROFAMILIA has lost the monopoly it had on family planning in Colombia and will have to confront aggressive and ample competitors. On the positive side, PROFAMILIA has gained new opportunities it is already exploring. Various entities that are helping to carry out the new law have begun to contract with PROFAMILIA to obtain various services. (See Section 3.2.5.)

With Law 100, it is unlikely that PROFAMILIA will retain its predominant position as a provider of family planning in the future. The most probable scenario will involve other health delivery organizations' adding family planning to their range of services and PROFAMILIA's continuing provision of family planning and reproductive health along with more general health services.

7.2 Continuing Needs

Despite the positive scenario presented above, there are still many needs, many unknowns, and many actions that will need to be taken. Some of the more general needs in the health sector involve careful assessment of existing and future human resources. Part of this assessment should cover training needs and strategies. Within the area of reproductive health, unmet needs for family planning still exist. One or more institutions should take the lead to ensure that family planning remains an established and secure component of everyday life by providing general health services and that there is no longer a need for the specialized programs of the past. Furthermore, there is a need to ensure universal understanding of the health reform. Information explaining the changes brought about by the new health law should be provided to all Colombians. Although the majority of Colombians know about the reform and the rights they have gained, interest or pressure groups should be formed to ensure that health administrators perform their duties and offer family planning services without further delay.

7.2.1 Human Resources

The human resource situation in health care is one of the biggest problems confronting health authorities and planners in Colombia today. World Bank figures (1993) indicate that for 1988–1992, there was less than one doctor (0.87) per 1,000 people. Government policy limits the number of specialists so that the majority of existing physicians are generalists. Not surprisingly, physicians at all levels of specialization are concentrated, as a result of their personal preferences, in the larger cities thereby creating an unequal resource distribution. Restructuring of the higher education system in 1980 (Laws 80 and 81) caused many more schools of medicine to open, which created a huge increase in the number of trained physicians.

The situation in the nursing profession is even more critical because there is only one nurse for every 1.8 physicians. Nurses are poorly recognized for their work, receive low salaries, and have a low status. These negative factors, in addition to the fact that the training period required to become a doctor or a nurse is almost equal, have diminished interest in the nursing profession. Nurses find more recognition in management or health administration than in nursing care, so naturally they prefer to work in administration. Hospitals try to compensate for the lack of nursing care by employing a large number of auxiliary nurses.

Nurses have traditionally dedicated themselves to preventive health: vaccination, growth and development, prenatal care for pregnant women of low risk, and family planning with temporary methods. This specialization in the role of nurses and the ample delegation of functions in MCH seems largely the result of training in nursing schools. The curriculum includes a strong MCH component with both theoretical and practical training designed to give students the knowledge and ability to carry out specific tasks. The existing training

for nurses in family planning, coupled with the lack of such training for medical students over the past two decades, makes the Colombian nurse the primary provider of temporary family planning methods, including NORPLANT, in both public and private programs.

For the future, the role of nurses in family planning and reproductive health programs should be enhanced. Such programs form the basis of health promotion and prevention and should be the responsibility of nurses in the new system as it is evolving in Colombia. Ideally, the status of nursing should be improved, and the course of study should be modified to give nurses the special training needed in sexual and reproductive health. Such measures would help to make the profession more attractive and also to attract better candidates to the nursing profession. In the course of implementing the health reform, we should carefully keep basic services in sexual and reproductive health from becoming too dependent on physicians and thus overly medicalized.

7.2.2 Institutionalizing Training for Family Planning

Part of the successful implementation of Colombia's health reform will involve developing and carrying out a plan to institutionalize training of health personnel in sexual and reproductive health and in family planning. The lack of an adequate system for training health personnel in these areas was a key factor impeding the MOH's family planning program in the past. The schools of medicine and nursing should assume this responsibility and should incorporate this training of students both at the undergraduate level and as part of the specialization in obstetrics and gynecology. This role for Colombian universities should be extended to enable them to serve as centers for continuing education, thereby introducing the latest contraceptive technology and new information on sexual and reproductive health.

Since the early 1970s, Colombian medical students have not received training in family planning, thus requiring periodic remedial programs. These courses were organized and financed centrally, and the people who received this training generally were recently graduated physicians in their year of social service. Some of these physicians were not interested in family planning because their preferred area of medical practice was not obstetrics and gynecology.

A new approach to training was tried during the 1990s, thanks to the MOH's decentralization that redirected control of programs to the departmental level. The Sectional Health Service of Antioquía and the Metropolitan Health Institute of Medellín (METROSALUD), with the collaboration of AVSC International, selected two hospitals where a permanent, reliable, and accessible training system in family planning could be established. The Marco Fidel Suárez Hospital in Bello and the *Unidad Intermedia de Castilla*/Castilla Intermediate Unit were selected. These two hospitals of second-level care have human and technological resources similar to those of most of the country's hospitals.

The training strategy involved setting up a multidisciplinary team of hospital personnel composed of physicians, nurses, psychologists, and social workers. When obstetricians and gynecologists were in these hospitals, they were asked to work with general physicians who wanted to participate in the program. For each of the professional disciplines, functions were defined and a system of collective leadership was established to stimulate teamwork. The staff was trained in all components of a family planning program: contraceptive technology, counseling, community education, patient and procedure management, and planning. Finally, hospitals were given the necessary equipment and commodities to implement the program. Doctors were trained in surgical techniques in the same hospital with the available equipment and resources. The personnel's task in the hospital began by obtaining the necessary patients for training. For this, it was necessary to inform, educate, counsel, perform a medical exam, complete a clinical history, and obtain informed consent.

This training produced very good results because special attention was given to detail, and consistent communication was maintained with all involved personnel from both hospitals (the Sectional Health Service and METROSALUD) and from AVSC. After one year of activities, the family planning services were highly regarded and had generated enough steady demand for services to fill two surgical sessions per week. Following this successful trial run, the training program was presented to other hospitals in the area.

The training model with some modifications (caused by geographic distances and time) has been used to expand family planning activities in other departments. Health services were selected to participate on the basis of their level of interest in establishing the programs and their having a training center. When the health service personnel showed interest, they were invited to choose a hospital that could act as their training headquarters. Following this basic model, training centers were set up in at least half of the departments in Colombia.

One of the authors of this report actively participated in developing this initiative. In his opinion, positive results were obtained because of the understanding that the major impediment was poor management rather than a lack of training in the medical aspects. The program's proponents at each site assisted the health staff with resources and technical material, but most of all they served as instructors who could carry out the initiative. In the course of preparing this report, the authors visited two hospitals that had been training centers. Although the training experiment ended several years ago, these hospitals continue to offer family planning services, and the teams that were created are still working together. In addition, the approach to administration and management used in the training program has been applied to other hospital programs, suggesting that the training methodology may be valuable more widely in the health care field.

7.2.3 Unmet Needs for Family Planning

As noted, contraceptive use in Colombia is very high. Even so, there are still unmet needs for family planning and reproductive health services. According to the 1995 ENDS, the vast majority of women in union (91 percent) report that their needs for contraception are satisfied. On average, only 7.7 percent of women in union report that they have unsatisfied needs either to space or to limit the number of future births. Younger women report higher levels of needs (over 16 percent for 15- to 19-year-olds and almost 15 percent for 20- to 24-year-olds).

Identifying unmet needs for family planning may entail a broader approach to defining the concept as well as closer scrutiny of survey data. As Dixon-Mueller and Germaine (1992) have pointed out, additional unmet needs may exist among women who are not in union (especially adolescents) but are sexually active. Furthermore, current users of contraception may also have unmet needs. For example, some current users who definitely want to postpone or avoid pregnancy may be using ineffective methods or may be using a method incorrectly and therefore need better information or different methods. Among contraceptive users in Colombia, about 13 percent still use less-effective traditional or folk methods. Among reasons given for discontinuing use of a method, pregnancy was the reason about one-third of women using rhythm or folk methods gave. In addition, a large proportion of women (45.5 percent) reported that a pregnancy or birth within the past five years of the survey was unplanned (either mistimed or unwanted). Thus there appears to be ample evidence of continuing unmet needs.

Perhaps the most striking and troubling evidence of unmet need among Colombian women is the problem of abortion. Despite reduced levels of fertility and the wide use of contraception, the incidence of abortion is unacceptably high. This situation is paradoxical because Colombia is one of the few countries in the world where abortion is illegal for any reason. The problem of abortion has been recognized since the early 1960s, when data collection began.

One of the first studies of abortion, which was based on hospital admissions at the largest maternity hospital in Bogotá (Santamaría, 1967) for a one-year period in 1965–1966, reported more than 4,800 abortions and about 19,000 births. Some abortion patients had infections and some died. The costs associated with these abortions were several: the cost to the health and lives of the women, and the cost to the health system from treating women suffering from complications. Later research showed no diminution in the problem of abortion (Lopez et al., 1978). Studies from the 1960s and 1970s found abortion to be largely an urban phenomenon for women with moderate social and economic background. Women in rural areas and those who were the poorest and the least educated generally bore their children, while the most educated and well-off women used contraception to control their fertility.

A recent study, also based on hospital admissions, found that for 1989, there were nearly 77,000 abortions in Colombian hospitals (Singh and Wulf, 1994). After adjusting for the

number of spontaneous abortions and those that did not involve a hospital stay, the annual number of induced abortions may range from 173,000 to more than 400,000. Assuming 875,000 births per year (CELADE, 1997), there may be one abortion for every two to five births. This high level of abortion remains a critical public health problem in Colombia.

7.3 USAID's Future Relationship in Population in Colombia

After 30 years of assistance, USAID ended its support to Colombia's population program in 1996. As a final act in this long, productive relationship, the USAID Office of Population and the LAC Bureau funded the preparation of a report on family planning and population programs in Colombia and on the lessons learned from this experience. Documenting the Colombia success story and disseminating the results are important and appropriate. Hence this report. Appendix E summarizes the many lessons learned from Colombia's programs. The lessons cover a variety of topics including general lessons on policy and program development, training, and management, as well as lessons from PROFAMILIA's experience on management policies and strategies, personnel, finance, service delivery programs, research, and evaluation.

Since USAID is an agency with a serious, long-standing commitment to development, its interest in Colombia should not end with the termination of financial support or with the publication of this report. Therefore, one aspect of the report concerns what future relationship USAID should have in population in Colombia. The authors have identified two facets of a future relationship.

7.3.1 Tracking of Future Trends in Population and Family Planning

Through its worldwide population assistance program, USAID has supported one of the most extensive survey programs in the social sciences. The DHS Project and its predecessor projects have participated in a total of six national surveys in Colombia, from the first national fertility survey of 1969 through the most recent DHS of 1995. The availability of this information over time has helped to document the story of fertility decline and the dramatic increase in contraceptive use in Colombia. It is certainly in the country's interest, but also in the donors' interest, to continue to monitor these trends. In collaboration with other donors, USAID and the appropriate Colombian institutions should support a follow-up DHS in the year 2000 to track changes not only in basic demographic and health variables (fertility, infant mortality, maternal and child health), but also in the use of health services such as family planning.

As an additional part of the follow-up, USAID should revisit the Colombian population program in another four or five years (2001 or 2002 when results of the next DHS would be available) to assess how the delivery of family planning and other health services have evolved in a much transformed health sector. Given the major commitment that USAID has made over the years to PROFAMILIA, the authors also suggest that special emphasis in this review be given to changes in PROFAMILIA: its mission, its level of self-

sufficiency, its profile and extent of services offered, the profile of its client population, and especially changes in contraceptive use. The scope of work for this revisit should include a review of the indicators in Tables 10 and 11 on the basis of DHS in the year 2000, and PROFAMILIA records and statistics.

Table 10

**Indicators to Assess Changes in Population and Family Planning
in Colombia, 1995–2000**

INDICATOR	1995	2000*
TFR/Residence		
Urban	2.5	
Rural	4.3	
Total	3.0	
TFR/Education		
No school	5.0	
Some primary	3.8	
Secondary	2.6	
Secondary +	1.8	
CPR/Residence ^a		
Urban	74.4	
Rural	67.0	
Total	72.2	
CPR/Age		
15–19	50.7	
20–24	60.8	
25–29	71.9	
30–34	78.1	
35–39	82.4	
40–44	78.5	
45–49	64.2	
CPR/Method		
Pill	12.9	
IUD	11.1	
Injection	2.5	
Implant	0.7	
Vaginal	1.4	
Condom	4.3	
Female sterilization	25.7	
Male sterilization	0.7	
All Modern Methods	59.3	
Rhythm	5.2	
Withdrawal	5.8	
All Traditional Methods	11.1	
Folk Methods	1.8	

Table 10 (cont.)

**Indicators to Assess Changes in Population and Family Planning
in Colombia, 1995–2000**

INDICATOR	1995	2000
Modern Method Use by Source		
Public Sector	27.1	
Hospital	18.2	
Health Center	4.7	
Social Security	3.6	
Other Public	0.6	
Private Sector	72.1	
PROFAMILIA	28.8	
Hospitals/Clinics	6.2	
Pharmacies	33.1	
Private Physician	3.2	
Other Private	0.8	

Source: PROFAMILIA and Macro International Inc., 1995.

^a For women in union.

* Figures for the year 2000 will be provided when and if a follow-up assessment is carried out.

Table 11

Indicators to Assess Changes in PROFAMILIA, 1997–2000

INDICATORS	1997 ^a		2000*
Number of New Acceptors by Method in Clinic Program			
Pill	4,736		
IUD	50,645		
Injection	8,738		
Implant	8,116		
Vaginal	604		
Condom	849		
Female Sterilization	46,677		
Male Sterilization	5,539		
Profile of PROFAMILIA Clients for Family Planning by Education	(1996)		
No School	1.2		
Primary	17.2		
Secondary	62.4		
Secondary +	19.1		
Total	100.0		
% of Clients with Unsatisfied Basic Needs ^b	(1995)		
	13.3%		
% of Satisfied Users ^c	97%		
Comparison of clients' preferred method and the method actually received	(1996)		
	(% distribution)**		
	Method preferred	Method received	
IUD	31.3	31.0	
Pill	3.8	3.9	
Vaginal/Injection	4.8	8.0	
Male sterilization	4.5	4.5	
Female sterilization	44.9	44.1	
Implant	8.7	8.3	
	100%	100%	
% of Clients Whose Family Planning Services Are Paid for by a 3 rd Party	20%		
Income by Source	in US\$	%	%
Donations	1,979,468		11.6
Sales	1,137,928		6.6
Family Planning	825,714	4.8	
Diversification	312,214	1.8	
Medical	11,379,65		66.4
Family Planning	3,524,905		
Diversification	7,854,753	20.6	
Other	2,635,836	45.8	15.4
Total	17,132,890		100.0

Table 11 (cont.)**Indicators to Assess Changes in PROFAMILIA, 1997–2000**

INDICATORS	1997	2000
Self-sufficiency ^d	86.4 %	
Number of Local Contracts and Total Value for Services		
Social Security	40 for value \$4.2 million	
EPS	27 for value ^e	
ARS	5 for 82 million pesos	
Other	119 for value ^e	
Number of Contracts and Total Budgeted Value with External Entities ^f	17 agreements \$3.2 million	
Number of Technical Assistance Assignments for PROFAMILIA Staff	3	
Number of Visitors to PROFAMILIA for Technical Assistance from What Countries	5 Bangladesh, Bolivia, and Ecuador	

* Figures for the year 2000 will be provided when and if a follow-up assessment is carried out.

**Figures are rounded. Sum of figures do not equal 100%

^a New users for 1997.

^b PROFAMILIA developed a simplified measure of Unsatisfied Basic Needs (the original was developed in the ENDS, 1991) that is an index based on the following factors: houses with plumbing, toilet, and electricity, and households where the head of household has less than three years of schooling.

^c PROFAMILIA, 1995. From a national sample of users, 43.4 percent said services were very good and 53.2 said services were good for a total of 96.6 percent.

^d Proportion of income from local sales, medical services, and other (investment income, rental, and contracts) to total expenses.

^e Several of these contracts have an unspecified value, so no dollar amount is shown.

^f On the basis of PROFAMILIA table, Relacion de Proyectos Subvencionados por Distintos Donantes through August 1997.

USAID should support the preparation of a follow-up report and its dissemination both to policy makers and to administrators of family planning and reproductive health programs in developing countries.

7.3.2 Defining a New Partnership between USAID and PROFAMILIA

In the coming years, USAID's assistance in population planning will end in other developing countries. Brazil and Mexico are future candidates in the Latin American region. Although Colombia is not the first country to have graduated from population assistance (Costa Rica and Chile did so in 1994 and 1995, respectively), certain characteristics of the past relationship between USAID and Colombia make it a worthwhile and appropriate testing ground for a new partnership. These characteristics

include the long-term nature of USAID's assistance to Colombia and the assistance that was given largely to a private institution, which succeeded in becoming a major service provider of family planning with a high level of self-sufficiency. Furthermore, PROFAMILIA not only has been a recipient of USAID assistance, but also has contributed its expertise over the years to the betterment of programs in other countries.

A reasonable legacy of USAID's past relationship with PROFAMILIA would be USAID's willingness to use its continuing influence (a) to help PROFAMILIA remain a vital part of the international community of family planning and health providers and (b) to keep PROFAMILIA's staff technologically up-to-date. USAID's influence would extend to other donors, to networks of technical assistance agencies (i.e. the CAs), and to family planning and reproductive health programs around the world.

What would be required to continue the legacy?

- Participation in international fora on family planning and reproductive health (e.g., meetings held by IPPF, The National Council for International Health, APHA, and USAID CAs; special working groups and task forces on topics such as quality of care, sustainability, decentralization, postabortion care, and gender)
- Participation in medical and operations research projects to test new methodologies or program strategies (e.g., the introduction of new contraceptives and future operations research projects)
- Periodic publication of information and research results emanating from PROFAMILIA's program in the appropriate international journals and magazines (e.g., IPPF's *FORUM*, *International Family Planning Perspectives*, and *Studies in Family Planning*)
- Participation in donor and CA project assistance assignments, both in terms of PROFAMILIA staff participation in such assignments in other countries and in terms of visits to PROFAMILIA by donors, CA staff, and program staff from other developing countries
- Participation in occasional state-of-the-art training opportunities on family planning and reproductive health

How would these various types of participation be facilitated? PROFAMILIA is one of the institutions from 10 countries participating in the South-to-South initiative, Partnership in Population and Development. With funding from the World Bank, the Rockefeller Foundation, and the UNFPA, this group of partners has the potential capacity to provide different types of cooperation and training. PROFAMILIA is currently designing a three-year program for US\$2 million that will, if funded, enable the organization to develop an infrastructure that provides training in family planning and in sexual and reproductive health to institutions in other developing countries. As part of this initiative,

PROFAMILIA has already prepared a booklet on various training topics that it could offer including (a) organizing family planning and reproductive health programs; (b) implementing social marketing activities; (c) conducting planning, information systems, evaluation, and operations research; (d) implementing mobile service delivery and education programs; (e) setting up financial management systems; (f) organizing youth centers; and (g) organizing a legal services program (PROFAMILIA, no date). If PROFAMILIA's program is funded, this organization will go a long way to ensure its participation as outlined here.

USAID has the ability to encourage the involvement of PROFAMILIA in different CA projects. Ideally, this involvement should be planned as part of USAID's request for proposals (RFPs) for new technical assistance projects (e.g., the future POPTECH project). Just as some USAID RFPs require participation of a minority or women-owned firm, USAID could also request a certain level of participation from an organization such as PROFAMILIA to promote "North/South" to South assistance.

As noted, some USAID CAs have already drawn on the expertise of PROFAMILIA to carry out their work. Such involvement could be encouraged more in on-going projects, as appropriate, with the CAs receiving extra credit (additional funds if possible) to help cover additional costs such as travel. PROFAMILIA's management has long encouraged its senior technical staff members to be so engaged. One simple way to encourage further involvement would be to assemble the curricula vitae of key PROFAMILIA staff members and to provide copies to appropriate CAs and donors.

Modern technology can also be tapped to involve PROFAMILIA in various working groups and consortia on particular topics through Internet groups. As CAs and USAID set up such groups, they should invite PROFAMILIA to participate.

Finally, USAID is considering setting up an endowment fund for IPPF/WHR that could be a source of financial support enabling various organizations, including PROFAMILIA, to participate in international fora, to take advantage of special training opportunities, and to support visits by other countries' program staff members to

PROFAMILIA. USAID staff members who work on the design of this fund should allow sufficient flexibility in the use of the funds to enable a graduate and "new partner" like PROFAMILIA to assist other organizations.

8. OVERALL CONCLUSIONS

The dramatic decline in fertility between 1965 and 1995 from an average of seven to three children is at the heart of the success story in Colombia. The central role of family planning programs in bringing about the impressive increase in contraceptive use to 72 percent over this period is widely acknowledged. Other demographic, economic, social, and cultural factors that contributed to the enormous momentum for change are (a) the accelerated decline in mortality, with corresponding increases in life expectancy and the rate of population growth; (b) an accelerated urbanization process; (c) the modernization of the Colombian economy including improvements in the education of both women and men; and (d) the special nature of the relationship between Colombian Catholics and their Church.

Several enabling factors have been identified that help explain the role played by organized family planning in Colombia. First is the commitment of key Colombian institutions including those with a strong academic standing and a private, service delivery organization. These organizations effectively used research and evaluation to design and improve programs. Second is the considerable investment made in training nearly 4,000 Colombian professionals who were able to develop and carry out population research and family planning programs. Third is the level and flexibility of external assistance that was available to fund the development and expansion of programs. USAID, IPPF, UNFPA, and many CAs in population were the principal sources of financial and technical assistance that has been deemed so critical. Fourth is the technological revolution in contraception that gave Colombians ample choice among effective contraceptive methods. Fifth is the attitudes of Colombian women who were poised to take advantage of a program of modern contraception.

Although Colombia's success in population was achieved without a formal policy, there was a consensus among key officials and institutions that the population problem was important and required action. Population policy development that did occur was subtle and pragmatic, and it provided the necessary environment for private family planning service delivery.

From the mid-1960s to the present, PROFAMILIA has dominated the field of family planning in Colombia. PROFAMILIA contributed not only to the development of family planning services through its institutional infrastructure, but also to the creation of a consciousness of family planning in the minds of Colombians. Among the key elements in PROFAMILIA's successful management are (a) its strong, consistent guiding mission and the role of its leadership; (b) the translation of its mission into performance through effective program strategies; (c) its method of managing and measuring performance; and (d) the people and relationships associated with the institution. Because of the combined strength of these elements, PROFAMILIA is a model of an effective nonprofit organization in the field of family planning and reproductive health.

The evolution of PROFAMILIA's service program is replete with innovative strategies that have been useful not only in Colombia, but also in other countries. The service delivery strategies began from a clinic base, over time expanded into rural and then urban community-based distribution, incorporated radio and other means to promote services, added a contraceptive social marketing component, and established mobile units. After more than two decades of providing services, and with contraceptive use becoming ever more prevalent, PROFAMILIA converted its CBD and CSM programs into a community marketing program. Other effective service delivery strategies have focused on the special needs of males and adolescents. PROFAMILIA was innovative in changing the roles of service providers: CBD promoters distributed pills, and nurses inserted IUDs.

PROFAMILIA's experience in moving toward financial sustainability is long and productive. Its multifaceted approach to sustainability started with charging fees for services. PROFAMILIA developed a good system for tracking the "real" costs of services by method, clinic, and program or delivery strategy. It expanded into a broader range of reproductive health services that were provided for a profit and that served to cross-subsidize family planning. It also emphasized efficiency and reducing costs. Finally, in the new era of health reform under Law 100, PROFAMILIA has initiated numerous contracts for family planning and health services with social security and health insurance companies. PROFAMILIA is the deserving beneficiary of an endowment fund that moves it a step closer to sustainability and gives a welcome cushion for special program needs.

Although PROFAMILIA is a major part of the story of family planning in Colombia, there are other important institutional actors. Teaching hospitals played a critical role in the early days, and there are signs that they may play an increasingly larger role in the future. With few exceptions over the years, the MOH through its MCH Division has provided services to roughly one-quarter of the population of contraceptive users. Pharmacies, the pharmaceutical industry in Colombia, and private physicians have contributed to ensuring an adequate supply of contraceptives and services. Over this 30-year history, there are numerous examples of useful collaboration between the public and private sectors.

This report highlights the many lessons learned from Colombia's experience in population and family planning. These lessons span overall policy and program development, training, and PROFAMILIA's dynamic history. The future of family planning service delivery in Colombia is changing as the overall health sector is being transformed. The need for services in family planning and reproductive health will continue as each new cohort of Colombian youth enters the reproductive years. How these youths will obtain the services they need will depend on how the health environment evolves. From today's vantage point, it appears that PROFAMILIA will more than overcome the loss of a major part of its external support. In all likelihood, it will succeed in adapting to the new health environment and in continuing to provide quality family planning services; however, through a more general program of new health services. The challenges ahead for health care in Colombia involve the role and training of health providers, principally physicians and nurses, given the primary emphasis on preventive health care and the question of whether implementing health reform can meet the expectations of serving the needs of the entire Colombian population.

An appropriate legacy of USAID's 30 years of assistance to the population program will be for the donor community to ensure (a) that the lessons from Colombia and from the unique role of PROFAMILIA continue to serve as a model for programs in other countries and (b) that PROFAMILIA remains a vital part of the international population and health community.

APPENDICES

APPENDIX A

Scope of Work

Colombia Population Program

I Activity to be Reviewed

The Review Team will examine USAID's contribution to the Population Program of Colombia during the past 31 plus years with a primary focus on the past decade. The review will examine the program from a historical perspective and will focus on public and private sector activities, effectiveness and sustainability including lessons-learned.

The review will also establish a baseline of key indicators for evaluating the impact of the withdrawal of USAID support on program quality, access and sustainability at the end of the year 2000.

II Background

USAID has provided family planning and reproductive health assistance to the Government of Colombia, the International Planned Parenthood Federation affiliate, Asociacion Pro-Bienestar de la Familia (PROFAMILIA) and pre-service medical and other institutions for more than 30 years. Despite initial set backs during the early program years, which included organized resistance from religious groups, left-wing opposition parties, and even some sectors of the medical establishment, Colombia is one of the success stories of family planning assistance both in the Latin American and Caribbean region and in the world. In 1986, 65% of women in union used a contraceptive method. The contraceptive prevalence for all methods increased to 72% of women in union in 1995, (DHS data). In 1964 Colombia had a population growth rate of 3.3% and in 1995 that number had decreased to 1.8%. In 1995 Colombia had a population of 35 million people. At that time the population was 71% urban, with 67% of rural women and 74% of urban women reporting contraceptive use. Fertility declined from approximately 6.6 births per woman in the early 1960s to roughly 2.8 births per woman in 1995. There is universal knowledge of family planning methods with 99.6% of all women in 1995 reporting knowledge of at least one method. The table below illustrates the method mix from the last two DHS studies.

	1986	1995
Pill	16%	13%
IUD	11%	11%
Sterilization	19%	26%
Other modern methods	6%	9%
Other methods	12%	13%
Total All Methods	65%	72%

The Colombian Population Program is a mix of private non-profit, commercial and public sector services with most women receiving services from the private sector. In 1991 the political constitution of the Government of Colombia affirmed the role of public sector institutions to provide family planning services. The 1995 DHS found that 27.1% of current modern method users received their methods from the public sector with most services (18.2%) provided by hospitals and 4.7% provided by health centers. The private sector accounts for 72.1% of services, with PROFAMILIA providing 28.8% of services, drug stores providing 33.1% and private doctors providing 3.2%.

PROFAMILIA, created in 1965, is a private institution whose mission is to inform and facilitate access to contraceptive methods. PROFAMILIA currently has 47 women's clinics, eight men's clinics and 11 youth centers throughout 35 cities in Colombia. PROFAMILIA has four family planning programs: 1) the surgical program, 2) the clinical program, 3) the social marketing program and, 4) the "Over the Counter" program. The social marketing program has 38 distribution centers and provides contraceptives to drug stores and other sales points in all the municipalities of the country. In addition to family planning services, the institution provides other reproductive health services in its diversification program, including pregnancy testing, prenatal care, infertility, pediatrics, sonograms, mammograms, vaginal cytology, and general medicine. In 1989, PROFAMILIA provided 700,000 consultations of which 52% (364,000) were for family planning services. In 1994, due to the growth of the diversification program, there were more than 1,000,000 consultations, of which family planning services (about 36,000) represented only 3.6%.

USAID has provided assistance to PROFAMILIA directly and through the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR). The last assistance to PROFAMILIA ended in September 1996 and was provided through the Transition Project. All other USAID assistance to the population sector has ended since Colombia achieved high modern contraceptive prevalence and attained other key benchmarks in population and health. USAID also provided assistance to the Ministry of Health, to pre-service medical institutions and to local Departments since the government services were decentralized-- both directly and through Cooperating Agencies such as the Association for Voluntary and Safe Contraception (AVSC).

III Purpose of the Program Review

A The review will provide a comprehensive review of USAID's support to the Colombia population program.

B The study will provide an historical and programmatic review identifying and documenting the key lessons learned from the Colombian experience. The review will focus on USAID support for both the public and private sector.

C The evaluation team will identify and measure a key list of quality, geographic and economic access , coverage, volume and sustainability indicators that will be used as a baseline study These same indicators will be measured again in the Year 2000 to assess the impact and sustainability of the Colombian population program since the end of USAID assistance

Four different products will be produced as a result of the consultancy The first product will be a 25-30 page case study paper reviewing the Colombian family planning and reproductive health program including key lessons learned The audience for this product will be decision and policy makers The layout of this paper will be professionally designed in accordance with USAID guidelines This will be prepared in both English and Spanish

The second product will be a more detailed case study report that will supplement the information of the shorter paper designed for distribution among USAID officials, PVOs and NGOs, CAs, and other donors This report will be no longer than 50 pages and will include appendices of background materials reviewed and interviews conducted during the study This will also be prepared in both English and Spanish

The third product will be a brief Power Point presentation in slide form that can be used by USAID to highlight the program to policy makers This will be prepared in English

The fourth and final product of this consultancy will be the list and baseline measurement of the key transition indicators for measuring sustainability, quality, access, coverage, and volume with a discussion of how they are collected and measured so that future studies will be comparable This will be prepared in both English and Spanish

C The four products will be needed in final form by the first week in March 1998 for use in preparation the USAID/LAC R4 review process Draft products will be needed at least two and 1/2 months prior to this time (by Dec 15, 1997) for comments, clearance, and final preparation

IV Statement of Work

A Questions for the review team to address

1 What is the history of USAID's involvement with the Colombian population program?

2 What is the history of the overall program?

- 3 What are the important lessons learned from the Colombian experience?
- 4 Were policy issues addressed to achieve a successful program? If so, how were they identified and what strategies were utilized?
- 5 What has been the history of the program with the Catholic Church?
- 6 Has there been collaboration between the public and private sectors? How has USAID worked with both sectors and encouraged or discouraged this collaboration?
- 7 What specific interventions and strategies were used by the Colombian program to increase demand, access, and coverage?
- 8 How have community-based distribution and social marketing contributed to the overall strategy?
- 9 What part have clinical services played in the overall strategy?
- 10 How financially sustainable is the program? How was financial sustainability achieved?
- 11 How programatically sustainable is family planning in Colombia? How has this been achieved?
- 12 Has the program created economic access to services for low income and geographic access to underserved populations?
- 13 How does the cross subsidization of services for low income populations work?
- 14 How will the termination of USAID assistance likely affect the future of the program?
- 15 How has IPPF/WHR worked with PROFAMILIA to strengthen the institution's capacity and create financial sustainability?
- 16 How have CAs worked with the public sector institutions?
- 17 What are the lessons learned in Colombia for working with special populations such as males and adolescents? How was demand for vasectomy increased? How have the male clinics identified and incorporated ancillary services?
- 18 In what other reproductive health areas has the program worked and how successful has the integration of these services been?

V Methods and Procedures

A Data Sources

1 The evaluation team will review key documents including Demographic and Health Surveys, journal articles, project papers, project evaluations, management reviews, routine program reports and statistics, special studies, trip reports, other relevant information, and publications, such as, Contra Viento y Marea, 25 Anos de Planificacion Familiar en Colombia by Gonzalo Echeverry

B Methods of data collection

1 A desk review of key documents listed above will be conducted prior to field work in Colombia (A comprehensive list of documents for review will be compiled by USAID, the POPTECH Assignment Manager, IPPF/WHR, and the local consultant in collaboration with PROFAMILIA)

2 Key informant and in-depth interviews will be conducted with USAID representatives and others knowledgeable about the Colombian population program

3 A standardized questionnaire will be drafted and sent to key informants knowledgeable about the program prior to the field work

4 A field visit to Colombia will be undertaken to conduct interviews with key players and informants, to gather other relevant documents, and to visit private and public sector project sites

C Duration and timing

1 The field work will begin in mid-September 1997

2 One week preparation time will be budgeted for the international and local consultants for background reading

Proposed Time Line

Week One Background Reading/ USAID DC Briefing

Week Two Field Work Colombia

Week Three Field Work Colombia

Week Four Report Preparation (Comprehensive)

Week Five Report Preparation (Comprehensive)

Week Six Report Preparation (Short Paper)

Week Seven Report Preparation (Short Paper)

Week Eight Report Preparation

Week Nine (Power Point presentation preparation)

December 15, 1997 Draft of all products due

Jan 14, 1998 Comments received USAID/Colombia, G/PHN, LAC Bureau
Feb 7, 1998 Comments incorporated
Feb 21, 1998 Final draft prepared
March 7, 1998 Final Draft cleared

VI Team Composition and size

A The team will consist of an international consultant (Team Leader) and one local consultant. The international consultant will be hired with qualitative research experience and broad knowledge of public and private family planning programs in the Latin American region. The international consultant will have a Masters degree in public health or a related subject and at least five years experience in family planning and reproductive health. The team should have experience with clinical, CBD, and social marketing service delivery. The international consultant should be fluent in Spanish and is responsible for interviewing, analyzing the data, and preparation of all the documents in English.

The local consultant will have in-depth knowledge and familiarity of the Colombian program over the years and will be responsible for scheduling appointments in Colombia, interviewing, analyzing the data, and translation of the final documents into Spanish.

VII Reports

A The drafts of all products will be due on December 15, 1997

B The Final deliverables. Approximately 35 copies of the First Report (shorter case study) will be required (25 copies in English and 10 copies of the Spanish version). Approximately 10 copies of the detailed larger paper (5 in English and 5 in Spanish) will be required. Two sets of the power point presentation, (in English only) are required. Approximately 10 copies of the last deliverable on the Transition Indicators, (7 in English and 3 in Spanish) will be required.

C As indicated the original reports will be prepared in English and translated into Spanish by the local consultant.

VII POPTECH will be responsible for recruiting and managing the consultants, all travel and related expenses, and report editing and formatting in close consultation with USAID/G/PHN, the USAID/LAC Bureau, and the USAID/Colombia Country Representative.

APPENDIX B

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APPENDIX C

List of Contacts

PROFAMILIA

Fernando Tamayo, President, Board of Directors
Maria Isabel Plata, Executive Director
Jaime Guevara, Medical Services Director
Gabriel Ojeda, Evaluation and Research Director
Jaime Buitrago, Finance Director
Rodrigo Castro, Chief Accountant
Maria Emilia Naranjo, Director, Bogotá Clinic
Diego León Londoño, Director, Medellín Clinic
Rosalba Ramírez, Finance Assistant

Ministry of Health

Luz Elena Monsalve, Head, Human Development Unit

Instituto Materno Infantil

Pio Iván Gómez, Head, Ob/Gyn Dept., National University

Marco Fidel Suárez Hospital, Bello

Rafael Restrepo
Leopoldo Arbelaez
Octavio Yepes
Gloria Montes

Hospital General, Medellín

Carlos Echeverry, Head, Ob/Gyn Department

Unidad de Orientacion Materna “Orientame”

Jorge Villarreal, President

AVSC International

Alcides Estrada
Luz Helena Martínez
Rita Cecilia de Silva

UNFPA

Mercedes Borrero

Private Consultants

Alberto Rizo
Gonzalo Echeverry
Luis Fernando Duque

USAID

Duff Gillespie
Elizabeth Maguire
Richard Cornelius
John Coury
Carol Dabbs
Carl Hemmer
John Rose

USAID/Colombia

Carl Cira
Patricia Hurtado
Maria Eugenia Valencia

Former USAID

William Bair
Jerald Bailey (also former Population Council staff)
David Denman

AVSC

Santiago Plata (former PROFAMILIA and SOMARC staff)

IPPF/WHR

Alvaro Monroy (former USAID/Bogotá staff)
Marcia Townsend
Timothy Williams
Ann Lion Coleman (former IPPF/WHR staff)

Development Associates

Leonel Valdivia
Anne Terbough

Pathfinder International

Lindsay Stewart (former IPPF/WHR staff)

PATH

Anne Wilson (former Development Associates staff)

Population Council

Ricardo Vernon

Alexandra Durstine (former IPPF/WHO staff)

APPENDIX D

Questions for Report on the Colombian Population Program

1. What has been your association with Colombia's Population Program? What period of time does your association span?
2. For those knowledgeable about the **beginnings of the population program**:
 - What were the key policy issues in the first decade of the program? (government support/opposition, the Church's role, etc.)
 - How were these issues addressed, by whom, and with what outcome?
 - What was the early role/position of key private sector groups in population/family planning? What did these groups accomplish? What lessons are there from this early period in the evolution of the family planning program?
 - What was the early role/position of public sector agencies in population/family planning? What did these groups accomplish? What lessons are there from this early period in the evolution of the family planning program?
 - What was the role of the donor community and USAID in particular in the early years of the program?
3. For those knowledgeable about the **overall history of the population program** (1964 to 1997):
 - Explain the relative role of public and private institutions in the development and implementation of the program (especially the government's yielding to the private sector a dominant role for family planning)? What lessons are there in this for other countries or is Colombia unique?
 - If not answered in the above question, how have the public and private sectors collaborated in the development and implementation of the population program (name specific areas of collaboration)? Describe the strengths and weakness of this collaboration. Are there lessons learned from the collaboration?
 - If not answered in the above, what has been the overall history and relationship between the population program (public and private components) and the Catholic Church? Are there lessons from Colombia's experience for other countries?

- What are the key policy issues that have faced the population program over the past two decades? How have these been addressed, by whom, and with what result?
- What are the key policy issues for the future of the population program? How might these be addressed and by whom?

4. For those with knowledge of **PROFAMILIA**, at any time throughout its history:

- What are the key characteristics/strongest elements of PROFAMILIA's program? (structure, management, service delivery strategies, staff, training, research, monitoring and evaluation, etc.)

For any areas mentioned, why were these elements successful?

What lessons are there from these strong elements in PROFAMILIA's program for other countries' programs?

- Are there any areas of PROFAMILIA's program that were/are not particularly successful and/or that had to be modified or eliminated from the range of activities (by way of lessons learned for other countries' programs)?
- What specific interventions and strategies were used by PROFAMILIA to increase the demand for family planning (demand for child spacing/family limitation) such as policy, promotional, marketing, IEC campaigns and efforts, etc.?

For any of the areas mentioned, why was this an effective intervention?
What lessons are there from this intervention for other countries' programs?

- What specific interventions and strategies were used by PROFAMILIA to expand access to services such as different service delivery approaches and programs (hospitals, clinics, CBD, CSM, etc.).
 - If familiar with clinic services, how have these contributed to PROFAMILIA's overall strategy? What are the most important elements of these services (ask about lessons learned in this area for other programs)?
 - If familiar with the CBD and/or CSM programs, how have these contributed to PROFAMILIA's service delivery program? What are the most important elements of these services (ask about lessons learned in this area for other programs)?

- What specific interventions and strategies were/are used by PROFAMILIA to expand access to particular population groups (e.g., urban, rural, adolescents, men (e.g., vasectomy services), etc.)? What are the most important elements of these interventions (ask about lessons learned)?
- Cost if considered an important element of access to services. What strategies does PROFAMILIA use to deal with the cost of its services, setting fees, etc. for various population groups and to ensure access to low-income groups in particular (e.g., cross subsidization, etc.)? What lessons are there for other programs?
- What specific interventions or strategies are used by PROFAMILIA to improve the quality of services. Use following six quality of care to guide discussion:
 - Choice of methods
 - Information given to clients
 - Technical competence of service providers
 - Interpersonal relations
 - Follow-up and continuity of care mechanisms
 - Appropriate constellation of services
- What other health services in addition to family planning are provided by PROFAMILIA?
 - How has the integration of family planning with reproductive health services affected the program (access and use of family planning services, income generated by RH, other effects)?
 - What monitoring strategies or research does PROFAMILIA use to assess the impact of service integration?
 - What are there types of RH services that have presented special problems for program implementation? Are these lessons learned from this experience for other countries' programs?
- What other non-health services in addition to family planning are provided by PROFAMILIA?

- How has the provision of these services affected the overall program? Are there lessons learned from PROFAMILIA's experience in this area for other countries' programs?
- In what specific ways has USAID contributed to PROFAMILIA's program over the years? What have most the 3-4 most important aspects of USAID's work with PROFAMILIA?
- What will be the likely effect of the termination of USAID's assistance to PROFAMILIA on the future of the program? Is there any evidence yet of the effect of the termination of funding?
- What measures/indicators would you use to assess the impact of the termination of USAID assistance in the future?
- Over the years, various Cooperating Agencies (CAs) have provided technical assistance to PROFAMILIA. How have particular CAs contributed to the program?

IPPF/WHR:

Discuss contribution to PROFAMILIA's institutional capacity and financial sustainability among other topics

Population Council

AVSC

Others

- What lessons are there from PROFAMILIA's experience with CAs for other countries' programs (both positive and negative lessons)?
- In what specific ways have other donors (UNFPA and other bilateral donors as well as private foundations) contributed to PROFAMILIA's program over the years?
- If not answered previously, how financially sustainable is PROFAMILIA today? How was this sustainability achieved? What lessons are there from PROFAMILIA's experience for other countries' programs?
- If not answered in previous responses, how has PROFAMILIA worked with public sector agencies over the years? Are there lessons learned from PROFAMILIA's experience for other countries' programs?

- What do you believe to be PROFAMILIA's top 3-5 contributions to the population program of Colombia?
- Do you have any other comments about PROFAMILIA's program?

4. For those knowledgeable about service delivery **programs in the PUBLIC SECTOR**

- What are the key characteristics/strongest elements of public sector's program? (structure, management, service delivery strategies, staff, training, research, monitoring and evaluation, integration with MCH or reproductive health services, etc.)

For any areas mentioned, why were these elements successful?

What lessons are there from these strong elements in this program for other countries' programs?

- Are there any areas of the public sector's program that were/are not particularly successful and/or that had to be modified or eliminated from the range of activities (by way of lessons learned for other countries' programs)?
- What specific interventions and strategies were used by the public sector to increase the demand for family planning (demand for child spacing/family limitation) such as policy, education programs, IEC efforts, etc.?

For any of the areas mentioned, why was this an effective intervention?
What lessons are there from this intervention for other countries' programs?

- What specific interventions and strategies were/are used by the public sector to expand access to services such as different service delivery approaches and programs (hospitals, clinics, etc.).
 - For any area mentioned, what are the most important elements of these services (ask about lessons learned in this area for other programs)?
- What specific interventions and strategies were/are used by the public sector to expand access to particular population groups (e.g., urban, rural, adolescents, men, etc.)? What are the most important elements of these interventions (ask about lessons learned)?
- Cost if considered an important element of access to services. What strategies does the public sector use to deal with the cost of its services, setting fees, etc.,

for various population groups and to ensure access to low-income groups in particular)? What lessons are there for other programs?

- What specific interventions or strategies are used by the public sector to improve the quality of services. Use following six quality of care to guide discussion:
 - Choice of methods
 - Information given to clients
 - Technical competence of service providers
 - Interpersonal relations
 - Follow-up and continuity of care mechanisms
 - Appropriate constellation of services
- In what specific ways has USAID contributed to population programs in the public sector? What has been the impact of USAID assistance (positive and negative)? Are there lessons from this assistance for other countries' programs?
- Over the years, various Cooperating Agencies (CAs) have provided technical assistance to public sector agencies? How have particular CAs contributed to particular programs? Are there lessons from this assistance for other countries' programs?
- In what specific ways have other donors (UNFPA and other bilateral donors) contributed to programs in the public sector over the years?
- What have been the major contributions of programs in the public sector to the overall population program in Colombia?

Do you have any other comments about population programs in the public sector or the private sector and/or the relationship between programs in the two sectors?

APPENDIX E

Lessons Learned from Colombia's Experience in Population Activities

The lessons listed below are derived from the many interviews that the authors of this report had over the course of collecting information. Many of the lessons are drawn from the material presented in the previous pages. However, the basis for some of the lessons goes beyond what is included in this report.

Overall Policy and Program Development

1. The rationale for establishing family planning programs was based primarily on a health perspective and less on the demographic imperative of lowering fertility, although the high rate of population growth due to high fertility was recognized as a problem. A compelling health issue was preventing abortion both because of maternal mortality and morbidity and also because of the financial cost of treating patients who had experienced complications due to abortions. Because of the health emphasis, there was less resistance to developing family planning programs that addressed women's health and welfare.
2. The development of a consensus among leadership groups in the public and private sectors is necessary whether or not this consensus becomes codified as an official policy.
3. There needs to be a solid understanding on the part of some service delivery institutions (public or private) that quality services need to be provided and that there is an equally strong commitment to do that job.
4. Although work on both the policy and services tracks is important, the greater concentration of resources and effort should be devoted to expanding the availability of services. Without primary emphasis on making services available, progress or the lack of progress on the policy front could in principle have no impact on access.
5. In Colombia, efforts to work with parliamentarians were not a productive avenue for generating political support for population and family planning programs. What was of greater benefit was educating and developing support among journalists and the medical leadership.

External Support

1. The overall level of funding for population activities in Colombia was substantial and was very important. However, equally important were the timing of the assistance (ample funds were readily available when needed for trying new approaches and expanding service delivery) and the flexible mode of assistance through Cooperating Agencies.
2. The different sources of funding (several bilateral and multilateral as well as various private CAs) allowed some specialization in that certain funding agencies concentrated their assistance on different Colombian organizations. This was deemed important to ensure that funding was available for the different actors.
3. If a donor agency identifies an institution with remarkable leadership that shares its overall objectives, the agency should continue to support that organization's work for long enough to enable the organization to fulfill its mission. Such commitment in support will produce results.
4. Endowments, although a conservative way to invest money to assist in the long-term financial viability of a private institution, can provide a useful cushion for emergencies.
5. Supporting the training of a substantial number of Colombian professionals was one of the most effective investments made by USAID and is considered a key enabling factor in the successful development of the Colombian population program.

Training

1. A variety of training opportunities (short, medium, and long-term) in various disciplines was essential to develop a cadre of well-trained individuals who could develop and implement the research and service delivery programs.
2. Observational travel is a useful component of training.
3. Regional or centralized training efforts may be limited by several factors:
 - ? Training of medical doctors in certain procedures (e.g., sterilization) is usually limited by regulations that prohibit doctors from administering or practicing procedures in countries where they do not have a license to practice. Through an association with an academic institution or medical school, it may be possible to conduct the training.
 - ? Regional centers are probably not sustainable. The experience in Colombia is that regional training ended when external funding ended.

4. Teaching hospitals in Colombia are an excellent location for pre-service training because of the rotation of interns including doctors, nurses, and auxiliary nurses.
5. Since management of health programs in public and private institutional settings is very different, staff from public hospitals should best be trained in public health institutions. Training of public sector medical staff away from their own location of regular practice (e.g., a public hospital) limits the possibility of involving key administrative and supervisory personnel who may determine whether the integration of a new practice is feasible in a given institutional setting, including team building.
6. The selection of individuals to be trained and the actual amount of time devoted to training are important. Health personnel should be selected who are highly motivated, and the training should be of sufficient length to cover not only specific clinical techniques, but also the management aspects of programs, including team building.
7. Periodic follow-up of training (through seminars, site visits or even telephone calls) helps to keep those who have been trained motivated to continue using the new knowledge and skills.

Management Policies

1. Paying doctors extra in public health institutions to provide family planning services or to perform certain procedures (e.g., sterilization) does not yield the expected results, can lead to serious political problems, and can harm the program.
2. Emphasizing good research and evaluation as a program is being developed and throughout its growth will not only enhance the “scientific legitimacy” of the program, but will also help to keep the program improving over time. Follow-up studies of users and national fertility surveys are important aspects of a comprehensive research agenda and provide important data for management and program development.

Public and Private Sector Coordination

1. When the private sector is an active player in service delivery, keeping the relationship with the public sector informal and low-key may be the most productive avenue to ensure that services will be provided.
2. The private sector should keep engaged with the public sector to facilitate improvements in the national program.

Lessons from Profamilia

Management Policies and Strategies

1. Management should always have a clear vision of the institution's mission and stay focused on the institution's primary tasks. Without such a vision and focus, an institution's efforts can become too diffuse to have any real impact on its primary mission.
2. Leadership with an entrepreneurial spirit helps keep an organization open to innovation and change. For example, this spirit can turn a crisis (such as the end of external assistance) into new opportunities and growth.
3. The Board of Directors should include individuals of high standing and with influence in the society and in business. The stature of the Board members coupled with the fact that the institution is private gives it a relatively free hand to develop the program despite political opposition to family planning programs.
4. Management should know how to use outside technical assistance to achieve its primary goal. The recipient organization should set the agenda for the assistance, not the institution providing the assistance.
5. External support should be used to try new strategies and to take risks. When that support ends, the institution should extract the most relevant lessons and apply them as appropriate in addressing the institution's primary mission and not be distracted to pursue tangential objectives.
6. As an FPA moves from being partially subsidized to one that is moving toward self-sufficiency, it needs to be managed increasingly like a business. Clinics need to be directed by people with administrative experience who may or may not be medical doctors.
7. Key characteristics of good management for FPAs include: a transparent and participatory management process (involving program directors, clinic managers, and Board members), good systems for supervision, use of information for resolving problems and making decisions, ability to adapt and change, and fairly decentralized clinic management.
8. One simple, effective management tool is weekly lunches among senior staff to review program issues and build consensus. This process ensures broader consideration of the impact of decisions and changes on various components of the institution's programs (e.g., clinic services, planning, and budgets).

9. Family planning organizations should have a unified reporting system for all donors and technical assistance agencies. Unified reporting helps to reduce time and effort spent on redundant and unnecessary technical and financial reports.
10. Management must be capable of cutting staff when program costs and lack of program output warrant such reductions. Without this ability, organizations may waste resources on unproductive program efforts.

Personnel Policies

1. Employees should be treated well to engender strong institutional loyalty. This means adequate (“competitive”) levels of compensation including good salaries and benefits. Benefits could include the possibility that staff could borrow money from the institution to meet extraordinary personal needs. The average tenure of employees is a good indicator of institutional loyalty.
2. There should be opportunities for internal promotion.
3. Staff development and training should be a priority from day one of a person’s employment. This emphasis helps to develop a competent, committed staff who know that the institution values its role.
4. Others, in addition to top management, should have opportunities to attend international meetings and represent the institution. This exposes staff to other programs and increases staff commitment to the institution. Further, senior staff should be given paid leave (e.g., up to 15 days per year) to work on assignments in other places, although they should cover their own travel costs.

Financial Policies

1. The ability for an FPA to purchase its own buildings is one effective way to keep yearly expenses from escalating, but this requires sufficient capital to make such purchases. Given the current costs of real estate and availability of donor support, this would be much more difficult, if not impossible, today.
2. A non-profit organization should have a policy of not depending too heavily on one source of funds whether that source is international or local (e.g., in Colombia PROFAMILIA has contracts with more than one social security organization).
3. Having self-sufficiency as an organizational priority is important since it can result in better management and more efficient programs. In addition, it should be a long-term institutional goal since it cannot be achieved overnight.

4. A non-profit organization should have a policy of generating income from the sale of services and activities. Such a policy is important both to produce real income to offset costs and pragmatic in terms of long-term institutional development and survival. However, there needs to be a balance between setting fees and ensuring access to services. The poorest people will not get services unless there is some subsidization for them.
5. Users of family planning services should pay something for the services they receive. The reasons for this policy are (1) people will value the service more and be more inclined to use it; and (2) there will be no question of voluntary use given that some payment, however small, is required. This policy can be extended to issuing “credit” to those who cannot pay at the time of receiving a service. If so encouraged, they will eventually pay for the services they received either in money or in kind.
6. The strategy of diversifying services beyond family planning is an essential element for cross-subsidizing family planning and for increasing self-sufficiency. As part of a diversification plan, clinic space can be rented to other health providers as a source of additional income or contracts can be made between the FPA and other providers to expand the range of services and generate income.
7. Hiring a local resource development officer or fund raiser may be a useful strategy for generating local financial support. However as with all program expenses, it is necessary to assess the productivity of fund raising efforts after several years to ensure that the income that is generated more than offsets the costs.
8. In developing new project activities that are donor supported, an organization should refrain from incurring expenses until the grant funds are in the bank. On occasion, promised program funds have not materialized causing financial difficulties and hardship for personnel hired to carry out a new project.
9. In addition to generating income, it is equally important to look for ways to cut program costs and to look for new ways to produce services efficiently without jeopardizing quality. As a program develops it will be necessary to alter or even eliminate activities that are too costly or unproductive (e.g., closing clinics that have too few clients, moving from a labor-intensive CBD program to a commercial marketing program.)
10. Outsourcing for certain activities can save the institution money and headaches (e.g., renting vans when the need arises to transport clients). This option obviously depends on the reliability of a rental service and may require a certain level of economic development in the country.

11. Since family planning is a very narrow niche of health services, true self-sufficiency of family planning services alone is not feasible. This is especially true if the prospective population of users is from the lowest economic status.
12. Self-sufficiency for adolescent reproductive health programs can never be achieved given the limited ability of youth to pay for services. Institutions that include adolescents among the prospective client population must have an outside source of funding or be able to cross subsidize these services.
13. Neither the interest nor the principal from an endowment fund should be used for operating expenses. The interest can be used for special capital expenditures that will enhance the organization's ability to generate funds or for emergency activities such as serving unanticipated refugee populations.

Program Policies

1. A useful, initial program strategy can be simply meeting an existing demand for family planning services by building a network of clinics and then by providing services where people live through a community-based distribution program. Over time the strategy of meeting clients' needs may result in providing additional services (e.g., legal services) or in organizing services for special population groups (e.g., adolescents, males).
2. Two sources of information may be useful for demonstrating a demand for family planning: the gap between desired number of children and actual family size; and also the prevalence of abortion, sometimes estimated from the number of patients seeking care in hospitals due to complications from abortions.
3. Adhering to the client's desire for a particular contraceptive method (unless contraindicated for health reasons) is an effective procedure for increasing client satisfaction with the services.
4. Satisfying clients' needs is an essential program policy since this is an effective way to promote use of the services to a wide range of prospective users.
5. Emphasizing a high quality of services is an effective way to promote use of the services. Clients appreciate good quality, will seek such services, and will talk to friends and other prospective clients about them.
6. Having a large number and national distribution of clinics (at least one per department), allows clinics to serve as an important reference point and back up for outreach programs: referrals for users, location for staff training and meetings, and storage of supplies.

7. Having a policy to allow distribution of oral contraceptives without a prescription is a pragmatic, useful way to expand access to this method. The justification for the policy in Colombia is based on (1) the existing practice of providing medications without the “required” prescription at pharmacies, (2) the fact that pregnancy is a greater health risk for women than pill use, (3) that hypertension—a contraindication for pills—is a relatively uncommon problem for women in Latin American, and (4) the impracticality of requiring a doctor’s examination prior to administering contraceptive pills especially in rural areas. In the context of Colombia, and other Latin American countries with similar experiences, there have been no adverse repercussions of this policy.
8. Allowing nurses to insert IUDs is an appropriate delegation of responsibilities and effective way to expand access to this method since in most countries the number of doctors is much more limited than the number of nurses.
9. Maintaining innovation in the development of program strategies is made easier if new approaches are tested through small efforts, coupled with evaluation to test their effectiveness, and then the best parts (but not necessarily the entire model) used for program expansion or scaling up of activities.
10. Along with a propensity for innovation, an institution should document and share its program experiences with others in the same field and in other countries.
11. Among the range of diversified health services, pregnancy testing is a useful and inexpensive way to draw new clients. At the same time, other more costly services, such as mammography, offer women a fuller range of reproductive health care.
12. Use of an institutional logo (e.g., the Green Flag) is an easy and useful tool to ensure that potential clients know where to get services.
13. Radio advertising can be an effective way to increase awareness and use of community-based services.
14. Condom advertising for STD/HIV/AIDS prevention by an FPA is effective and does not appear to damage the institution’s reputation for serving the general population since the average client is also interested in such prevention measures.
15. If permitted by donor agencies and in accordance with local laws governing activities with non-profit organizations, the sale of donated contraceptive commodities to individual clients and to commercial entities (when an established commercial marketing system does not exist) is a useful way to generate program income. Similarly, there may be opportunities to sell other commodities related to reproductive health services (e.g., specula) for a profit.

Research and Evaluation

1. A culture of using data for monitoring and evaluation has to be developed, it doesn't happen automatically. Strong support for monitoring and evaluation needs to come from senior management and the Board of Directors. Special training sessions may be needed for senior staff including clinic directors on how to interpret and use monitoring data.
2. Documenting program activities and outputs is important to ensure that donors and technical assistance agencies know how funds are being spent and what the results are. This further helps an institution to develop a reputation for being reliable and for carrying out what was promised.
3. In setting up management information systems, two basic types of data are required: program and financial information. There are four steps to developing information systems: conceptualizing the information needed; defining the specific type of information needed and developing the instruments to collect the information; checking the quality of the information collected; and providing feedback.
4. Program information should not be kept secret. Program staff at all levels need information on the program to judge its effectiveness and to determine whether changes in strategy are warranted to better serve clients' needs.
5. Tracking the costs of program activities and estimating the full costs of providing different services are important parts of good cost accounting and provide necessary information for developing financial self-sufficiency.
6. Consistency in the type of data collected over time should be a general rule for an organization so that data are comparable. Occasionally it may be necessary to adopt some additional measures to respond to donor needs. For example, PROFAMILIA has always used the same conversion factors for calculating CYPs. They temporarily compiled an additional set of information using USAID's modified factors.
7. A centralized monitoring and evaluation office or staff is an efficient way to carry out these needs within an organization as long as there is regular, useful communication among clinic and program directors so that their information needs are satisfied.
8. In addition to routine monitoring data, special studies are needed from time to time since service statistics don't always provide the answers to questions about the program (e.g., special client profile surveys, studies to assess quality of services, client satisfaction, patient flow analysis, operations research, and impact studies).

9. Applied or operations research (OR) is very useful for assessing the feasibility and merits of a new program strategy or other innovations (e.g., both PROFAMILIA's CBD and male programs were tested and improved through OR).
10. Using some of the institution's own resources to help fund a national DHS will increase the use of the data by the institution.
11. The local agency conducting a DHS should solicit interest in the survey from potential institutional users (e.g., a national nutrition institute) in the country and may also be able to get funding from these users for part of the survey and for special analyses.
12. The local agency conducting a DHS should maintain the master sample from the survey and sell it to interested clients in the country including public sector agencies (e.g., the national planning department).

APPENDIX F

Statistical Tables

Table A1

Selected Statistics on PROFAMILIA's Family Planning Program, Selected Years, 1965–1997

Program TYPE	1965	1975	1985	1995	1997 (6 MONTHS)
Clinical FP					
New Client Visits	83	75,310	104,538	158,104	71,703
Control Visits	0	266,048	201,083	246,858	100,489
Total Visits	83	341,358	305,621	404,962	172,192
Surgical FP					
Female Sterilization		8,397	45,679	68,295	22,731
Vasectomy		930	1,241	6,825	2,684
Total Sterilization Procedures		9,327	46,920	75,120	25,415
Sales of Pills^a					
Over-the-Counter at Clinics		826,105	130,591	13,967	12,495
Social Marketing		472,801	2,649,400	5,393,920	407,335
Community		875,468	2,083,780	0	0
Total		2,174,374	4,863,771	5,407,887	419,830
Sales of Condoms					
Over-the-Counter at Clinics		680,056	147,473	94,469	76,712
Social Marketing		2,306,389	2,334,972	5,953,869	2,867,303
Community		397,838	929,880	0	0
Total		3,384,283	3,412,325	5,953,869	2,944,015

Source: PROFAMILIA, Tables 11, 19, 39, and 42, Febrero 1997, and Tables 1, 2, 6, 14, and 15, Agosto 1997.

^a Number of cycles of pills.

Table A2

Number of Clinic Visits by PROFAMILIA Clients for Family Planning, Diversified Services, and Total, Selected Years, 1989–1997

CLINIC PROGRAM	1989	1992	1995	1997 (6 MONTHS)
FP Visits	364,975	358,669	404,962	172,192
Diversified Services Visits	335,165	505,024	698,956	131,485
Total Visits	703,140	863,693	1,103,918	303,677
FP Visits as % of Total	52.3%	41.5%	36.7%	56.7%

Source: PROFAMILIA, Table 11, Febrero 1997, and Tables 1, 2, and 4, Agosto 1997.

TABLE A3

Number of Couple Years of Protection^a for PROFAMILIA, Selected Years, 1965–1977

YEAR	CYPS
1965	208
1975	440,121
1985	1,156,455
1995	1,901,983
1996	1,730,546
1977 (6 months)	611,416

Source: PROFAMILIA, Table 50, Febrero 1997, and Table 22, Agosto 1997.

^aThe estimation of Couple Years of Protection (CYP) at PROFAMILIA is based on the following indicators:

- First visit to a clinic or center for an IUD insertion: 30 months of protection
- First visit to a clinic or center for pills: 3 months of protection
- First visit to a clinic or center for other temporary methods (condoms, jelly, foam, vaginal tablets, etc.): 6 months of protection
- Female or male sterilization: 150 months of protection
- Norplant insertion: 30 months of protection
- 13 cycles of pills provided: 1 year of protection
- 100 condoms provided: 1 year of protection
- 100 units of Norform provided: 1 year of protection
- 100 units of Neosampoon provided: 1 year of protection
- 4 injections of Depoprovera provided: 1 year of protection
- 13 injections of Mesigyna: 1 year of protection
- 13 injections of Cyclofem provided: 1 year of protection
- 1 Cu-T provided: 30 months of protection

Table A4

Number of Couple Years of Protection for PROFAMILIA by Program, 1995–1997

PROGRAM TYPE	1995	1996	1997 (6 MONTHS)
Clinic	178,367	175,769	87,474
Surgical	939,000	876,712	317,701
Over-the-Counter at Clinics	47,051	48,631	28,340
Social Marketing	737,565	629,434	177,901
Total	1,901,983	1,730,546	611,416

Source: PROFAMILIA, Table 44, Febrero 1997, and Table 22, Agosto 1997.

Table A5

ASOCIACION PRO-BIENESTAR DE LA FAMILIA COLOMBIANA

Prefamilia

Estado de Ingresos y Gastos

(Expresado en US\$)

	1973		1980		1986		1990		1996		1997	
Tasa de Cambio	23.86	%	60.92	%	191.46	%	491.81	%	1,036.71	%	1,062.00	%
INCOME.												
												a 31-08-97
Donations												
1 Cash national	0	0.00%	124,688	2.59%	134,684	1.87%	119,404	1.27%	227,127	1.00%	203,517	1.18%
2 Cash international	0	0.00%	2,186,364	45.55%	3,441,609	47.89%	3,110,189	33.16%	4,487,694	19.56%	1,222,762	7.14%
3 In-Kind national (*)	0	0.00%	0	0.00%	668	0.01%	19,120	0.20%	93,233	0.41%	9,606	0.06%
4 In-Kind international (*)	0	0.00%	0	0.00%	813,688	7.12%	780,582	8.11%	878,410	2.54%	212,848	1.24%
5. Contraceptives int.	0	0.00%	472,211	9.80%	307,364	4.26%	568,744	6.06%	589,619	2.50%	331,136	1.93%
Total Donations	0	0.00%	2,792,254	73.94%	4,978,011	60.95%	4,576,019	46.81%	8,225,933	22.00%	2,779,669	15.55%
(*) Hasta 1983 las donaciones en especie no se reconocían contablemente porque no se valorizaban.												
Sales												
1 Clinics over the counter	0	0.00%	262,666	5.24%	242,319	3.36%	360,686	3.74%	1,112,763	4.88%	604,763	3.53%
2. Social Marketing	0	0.00%	226,611	4.88%	207,036	2.87%	3,630,927	38.71%	7,712,870	33.84%	2,286,602	13.35%
3 Community marketing (CBD)	0	0.00%	1,344,714	27.90%	1,234,628	17.11%	0	0.00%	0	0.00%	0	0.00%
4 Discounts/returned products	0	0.00%	(7,081)	-0.15%	(6,823)	-0.09%	(123,289)	-1.31%	(303,463)	-1.33%	(137,167)	-0.80%
Total Sales	0	0.00%	1,816,799	37.87%	1,677,268	23.24%	3,668,343	41.14%	8,622,270	37.39%	2,764,088	16.07%
5 Cost of sales	0	0.00%	(1,080,819)	-22.43%	(892,196)	-13.75%	(2,978,987)	-31.78%	(6,583,882)	-28.78%	(1,618,160)	-9.43%
Total Net Sales	0	0.00%	735,980	15.45%	785,062	10.49%	679,356	7.03%	2,038,388	8.61%	1,145,928	6.64%
Medical income												
1 Clinics	0	0.00%	418,367	8.88%	740,788	10.27%	1,226,786	13.08%	3,508,23	15.40%	3,067,966	17.91%
2 Laboratories	0	0.00%	216,148	4.48%	382,763	5.30%	614,308	6.55%	3,377,873	14.82%	2,724,240	15.90%
3 Surgical	0	0.00%	289,036	5.37%	468,862	6.38%	874,677	9.33%	6,226,647	27.32%	587,463	32.61%
Total Medical Income	0	0.00%	923,551	19.73%	1,592,413	19.93%	2,715,771	29.96%	13,113,613	57.54%	6,379,669	36.42%
Other income												
1 Investments income	0	0.00%	226,074	4.69%	312,317	4.33%	330,963	3.53%	627,368	2.31%	488,118	2.85%
2 Rental contracts other	0	0.00%	172,698	3.58%	236,674	3.31%	875,287	9.33%	1,268,047	5.51%	2,147,718	12.54%
Total Other Income	0	0.00%	398,772	8.27%	548,991	7.63%	1,206,249	12.86%	1,895,415	8.82%	2,635,836	15.39%
TOTAL INCOME	1,819,737	100.00%	4,819,459	100.00%	7,215,937	100.00%	9,379,386	100.00%	22,791,419	100.00%	17,132,890	100.00%
EXPENDITURES												
1 Surgical	0	0.00%	1,300,948	26.99%	2,227,376	30.87%	2,697,998	28.77%	6,680,993	29.31%	4,798,622	28.01%
2 Clinics	0	0.00%	1,432,214	29.72%	2,162,290	29.83%	2,547,318	27.16%	4,833,013	21.21%	3,473,124	20.27%
3 Laboratories	0	0.00%	126,691	2.63%	218,809	3.00%	320,378	3.42%	2,743,612	12.04%	2,104,261	12.28%
4 CBD	0	0.00%	1,203,611	24.97%	1,111,763	15.41%	0	0.00%	0	0.00%	0	0.00%
5. Social Marketing	0	0.00%	0	0.00%	89,203	1.24%	1,019,793	10.87%	883,864	4.32%	1,021,216	5.96%
6 Evaluation Investigation Statistic	0	0.00%	116,979	2.43%	202,711	2.81%	396,232	4.21%	762,166	3.30%	484,641	2.80%
7 Systems	0	0.00%	0	0.00%	64,317	0.75%	116,149	1.24%	246,038	1.08%	222,324	1.30%
8 Information Education Communication	0	0.00%	163,299	3.38%	0	0.00%	0	0.00%	1,241,908	5.45%	882,139	5.15%
9 Capacitation Organización & Method	0	0.00%	21,169	0.44%	92,379	1.28%	92,915	0.99%	341,822	1.50%	307,334	1.79%
10 Youth Centers	0	0.00%	0	0.00%	0	0.00%	42,568	0.45%	781,889	3.43%	629,217	3.68%
11 Rural Programs	0	0.00%	0	0.00%	0	0.00%	0	0.00%	276,184	1.21%	168,299	1.10%
12 Adequation of Clinics (Infraestructure)	0	0.00%	67,324	1.40%	0	0.00%	132,770	1.42%	1,131,769	4.97%	184,886	1.08%
13 Legal Assistance Programs	0	0.00%	0	0.00%	0	0.00%	61,068	0.54%	289,384	1.14%	182,903	1.07%
14 Institutional Promotion	0	0.00%	24,883	0.52%	24,896	0.34%	6,492	0.06%	313,298	1.37%	708,376	4.13%
15 Direction Finance y Administration	0	0.00%	824,816	12.97%	767,341	10.50%	910,364	9.71%	2,972,482	13.04%	2,439,730	14.24%
TOTAL EXPENDITURES	1,623,666	89.27%	5,672,642	105.24%	6,928,884	96.02%	8,332,669	88.83%	23,557,174	103.36%	17,537,072	102.36%
SURPLUS (DEFICIT)	195,071	10.73%	(252,583)	-5.24%	287,053	3.98%	1,047,377	11.17%	(765,755)	-3.36%	(404,182)	-2.36%

Table A6

PROFAMILIA
DONACIONES DEL EXTERIOR
I P P F

(Expresado en millones de Col Ps \$)

TASA DE CAMBIO EN PESOS	PERIODO	TOTAL I.P.P.F.	Efectivo		Especie	
			Compra Antico	Subvención	In Kind	Cash Commodities
\$1,052 00	1997*	1,427 5	250 7	953 3	97 6	125 9
\$1,035 71	1996	2,746 5	589 9	1,591 9	395 5	169 2
\$491 61	1990	1,246 1	279 6	600 6	306 2	59 7
\$191 45	1986	308 6	58 8	201 3	48 5	
\$50 92	1980	102 2	78 2		24 0	
\$23 66	1973	28 2	28 2			

(Expresado en U S \$)

TASA DE CAMBIO EN PESOS	PERIODO	TOTAL I.P.P.F.	Efectivo		Especie	
			Compra Antico.	Subvención	In Kind	Cash Commodities
1 052 00	1997*	1,356,939	238,308	906,179	92 776	119,677
1,035 71	1996	2 651,804	569,561	1,537 013	381,864	163 366
491 61	1990	2,534,733	568 744	1,221,700	622 851	121,438
191 45	1986	1,611,909	307 130	1,051,449	253 330	
50 92	1980	2,007,070	1 535,742		471 328	
23 66	1973	1 191,885	1,191,885			

* Enero - Agosto/97

Table A7

for Chart 2. Trends in Total Fertility Rate by Residence in Colombia, Selected Years, 1978–1995

PLACE OF RESIDENCE	1978	1980	1986	1990	1995
Urban	3.1	3.0	2.8	2.5	2.5
Rural	5.4	5.1	4.9	3.8	4.3

Sources: CCRP et al., 1979, 1981, and 1986; and PROFAMILIA et al., 1991 and 1995.

Table A8

for Chart 4. Trends in Contraceptive Use by Residence in Colombia, Selected Years, 1969–1995

SURVEY YEAR	URBAN	RURAL
1969	45.0	15.0
1976	54.0	32.0
1978	55.0	30.0
1980	54.0	37.0
1986	70.2	53.6
1990	69.1	59.1
1995	74.4	67.0

Sources: ASCOFAME, 1969; CCRP et al., 1976, 1979, 1981, and 1986; and PROFAMILIA et al., 1991 and 1995.

TABLE A9

for Chart 5. Trends in Contraceptive Use by Woman's Education in Colombia, Selected Years, 1969–1995

SURVEY YEAR	NONE	PRIMARY	SECONDARY	COLLEGE
1969	6.0	28.0	52.0	—
1976	20.9	46.0	64.0	—
1978	31.0	60.0	62.0	66.0
1980	36.0	37.0	59.0	57.0
1986	50.7	62.0	71.8	81.4
1990	52.6	63.3	69.4	76.8
1995	58.0	70.4	74.7	77.1

Sources: ASCOFAME, 1969; CCRP et al., 1976, 1979, 1981, and 1986; and PROFAMILIA et al., 1991 and 1995.